

HIV Partner Counseling and Referral Services

HIV prevention services for persons at greatest risk of exposure

STANDARDS AND RECOMMENDATIONS

May 2000



California Department of Health Services

Office of AIDS

HIV Education and Prevention Services Branch

HIV Prevention Policy and Program Development Section

Preface

The guidance in this document should be incorporated into all California Department of Health Services (DHS) Office of AIDS (OA)-funded HIV prevention, care, treatment and surveillance program protocol. These programs can include: HIV counseling and testing (C&T) sites, mobile public health clinics, community outreach programs, HIV Transmission Prevention Projects (HTPP), HIV/AIDS surveillance programs, early intervention programs (EIP), Community Based Care, Medi-Cal waiver and AIDS case management programs. Private and community-based organizations that do not receive state or federal funding may also benefit greatly from following the enclosed precepts, specifically with regard to staff training, service documentation, record keeping procedures, the appropriate use of notification and referral options, and quality assurance guidelines.

In this document, DHS/OA has attempted to address all relevant HIV partner service issues that involve the voluntary participation of the HIV positive original client and his or her sex and needle-sharing partners. Standards, to which all funded programs must adhere, are stated in ***BOLD ITALICS***. Recommendations for program implementation of policy are also provided as suggested procedures.

As research related to the care and treatment of HIV/AIDS develops and as the dialogue among health providers evolves and influences legislation, this document may need to be updated to reflect changes in state law and medical standards of practice. No set of guidelines is static. Nor can all issues that can and will arise be addressed. All written guidance must be flexible enough to allow for local program practices that may be unique to a specific environment or set of circumstances.

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Local Health Jurisdictions

San Francisco:

Barry Brinkley
Viva Delgado
Lyn Fischer-Ponce
Chris Geoghegan
Wendy Wolf, M.P.A.

Los Angeles:

Kevin Harvey
Tony Bustamante
Allan Yates

Alameda:

Susan Black

Kern:

David Martin, B.S.N., P.H.N.
Reuben Sosa

Long Beach:

Nettie DeAugustine

Sacramento:

Jan Fleming

San Diego:

Michael Bursaw, M.P.H.
Robert Gunn, M.D.
Steven Hart, M.A.O.M.

Centers for Disease Control and Prevention

Gary R. West, M.P.A.
Robert N. Kohmescher

Kellie Lartigue
Jill Leslie
Kay Smith-Aiken, M.Ed.

California DHS Domestic Violence Prevention Program

Deborah Cohen, M.A., M.P.H.
Carla Ainsworth, M.D.

California DHS Tuberculosis Control Branch

Rosalie Black, M.S.W.

California DHS Sexually Transmitted Disease Control Branch

Tom Ault
Enrique Coons
Stewart Coulter
Linda Desantis, M.Ed.
Alice Gandelman, M.P.H.
Paul Gibson, M.P.H.

Lorenzo Hinojosa
Ayo James
Greg Mehlhaff
Manny Olivas
Fern Orenstein, M.Ed.
Rafael Reyes

Joe Sanchez
Denise Tafoya, M.P.A.
Roger Tulloch
Prisciliana Quijada, M.P.H. Candidate
Carlos Zavala

California DHS Office of AIDS

Vanessa Baird, M.P.P.A.
Harold Rasmussen
Drew Johnson
Catherine Baker

Laurel Cima, M.P.H.
Carol Crump, M.F.T.
Augustine Detres
Mary Geary
Dorith Hertz, M.P.H.
Miren Klein

Moreen Libet, Ph.D.
Catherine Lopez, M.Ed.
Bill Rau
Carol Russell
Kathie Sullivan-Jenkins
Peg Taylor
Jan Vick, M.A.

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INTRODUCTION

“ ... the protection of the public’s health was not compromised by the protection of confidentiality. On the contrary, the protection of confidentiality was a precondition for the achievement of public health goals.”

-Bayer and Toomey, *“HIV Prevention and the Two Faces of Partner Notification,”*
AJPH, August 1992, Volume 82, Number 8

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INTRODUCTION

The California Department of Health Services/Office of AIDS (DHS/OA) is pleased to provide the *HIV Partner Counseling and Referral Services – Standards and Recommendations, 2000*. These guidelines represent the cumulative input of local, state and national program administrators and service providers. This collaboration of multi-disciplined specialists in both human immunodeficiency virus (HIV) and sexually transmitted disease (STD) has resulted in creating a comprehensive, up-to-date resource document intended for use in local public health HIV and STD programs. Covering the most significant issues related to HIV partner counseling and referral services (PCRS), it is designed to assist the reader in understanding California law relating to the notification of potentially endangered third parties. It addresses the equally important need to provide sensitive, meaningful and accessible services to clients and their sex and needle-sharing partners (S/NSPs). The broader relationship of provider-client trust is also emphasized to help assure that client-focused, partner-appropriate support services will be provided to HIV positive clients and their S/NSPs.

DHS/OA administrators regard the HIV PCRS program and its written guidance to be an evolving system of counseling and care that will be continually updated and tailored to adequately meet our HIV-affected clients' needs. Coupled with education, counseling, care and treatment services, HIV PCRS can play an invaluable role in the prevention of HIV exposure and transmission and the promotion of appropriate client/partner behavior change processes.

A Historical Perspective

Contact tracing is a "... discreet process which is conducted thousands of times each year for patients with STDs."

- quote from a disease intervention specialist, 1994

The identification, notification and referral-to-treatment of persons exposed to communicable diseases has been a gold standard of public health follow-up and care for many years. Records dating as far back as 1812 reveal that the King of Sweden ordered his provincial governors to trace venereal disease through outreach methods. Shortly thereafter, physicians were ordered to report infected persons and their partners to the clergy or the sheriff.¹ We can be grateful today for our enhanced awareness that the behavior changes we seek to help our clients achieve are more subtle and uniquely individual than that which would be accomplished by exacting shame or captivity as a consequence of infection and exposure.

Since the discovery of penicillin in the mid-1930's, the ongoing improvement of laboratory screening tools, and the more recent implementation of individual and community-level social and behavioral interventions, the rapid identification and treatment of curable diseases continued to strengthen community disease prevention and control efforts throughout the 20th century. During the 1960's and 1970's, STD control programs nationwide were establishing confidential contact tracing systems and developing sophisticated disease investigation skills and techniques.

In the earlier days of the AIDS epidemic, however, contact tracing was perceived to have limited value in HIV prevention to both care providers and their clients. In 1981, when young and otherwise healthy gay men in Los Angeles, San Francisco and New York were being diagnosed with immune suppressive disorders of an unknown cause, the need to interview household and sexual contacts was critical to identifying this disease and determining how it was transmitted. Once scientists concluded that blood-to-blood and sexual transmission were the likely modes of exposure, efforts directed towards education and prevention were emphasized and partner notification took on less significance. Coupled with the disturbing fact that persons with AIDS and communities most affected were readily becoming the victims of discrimination at work and home, implementing the STD model of contact tracing was not pursued as a priority for HIV service providers.

It is important to remember some of the social changes and contextual factors that played a part in shaping this epidemic. During the early 1980s, when infection with the virus was rapidly spreading throughout the gay communities in California and New York, there was a simultaneous “collective birthing” experience underway. Men and women felt free to “come out” and did so *en masse*. Ultimately forming a strong social identity and political alliance, the gay community joined in the surging social and sexual revolution already underway. Combined with drug experimentation, “free love” expressionism predestined the rapid spread of sexually transmitted diseases (STD) among gays as well as others engaging in high-risk sex. Recognizing this trend, by the early- to mid-80s, public health providers recommended that limited HIV prevention funding would be better directed towards mounting a broad-based education campaign that could target persons most at-risk as well as the general public. These well-prescribed educational efforts played a significant role in the decline of newly diagnosed rectal gonorrhea and early syphilis that was documented in the late 80’s. Although HIV providers coined the term “partner notification” to refer to HIV partner follow up in the later years of the decade, as a general rule, the service was not routinely offered to HIV positive clients in California health departments.

In 1985 the HIV antibody test was approved by the FDA and became available. Although treatments to relieve the symptoms of opportunistic infections had existed previously, medical alternatives to treat the virus directly were not available until AZT was approved in 1987. AZT was beneficial for some, but was limited in its efficacy and expensive to dispense. Thus, the very practical concerns about the limited value of partner notification were further fueled. Public health providers were consigned to continue to educate people at risk and wait for a cure. Until there were more effective treatments, the best that could be hoped for was that persons at risk consistently used latex condoms to prevent sexual transmission, clean syringes and cookers to prevent the spread among injection drug users, and that health care workers rigorously adhered to universal precautions in the work place.

PCRS Today

"In November 1997, the [California Medical Association] ... Board of Trustees voted to encourage all CMA members to offer voluntary partner notification assistance programs for all patients who are HIV infected by means of making appropriate referrals to the local health departments or by the physician providing the assistance themselves."

-Resolution 118-98, 1998 CMA House of Delegates Resolutions Regarding HIV/AIDS,
February 12-16, 1998.

Today, HIV PCRS providers focus their efforts on bringing partners to counseling, testing and other medical services through a coordinated approach involving HIV prevention, HIV care, HIV and STD treatment, and local field services. The ultimate goal of HIV PCRS is to interrupt in the spread of HIV by informing S/NSPs of their risk, offering HIV counseling and testing services, and referring both positive and negative partners to additional services that will help them to reduce their risk of transmitting/contracting HIV. PCRS is offered in anonymous and confidential HIV counseling and testing sites, expanded counseling services or newly identified HIV positive clients, early intervention programs, and HIV case management and community based care facilities. With today's promise of drug treatment to minimize the likelihood of perinatal transmission,² the hope of extending the lives of those persons already infected, as well as the demonstrated effectiveness of long term behavior modification counseling, the need to promote services that confidentially inform potentially-exposed partners becomes unmistakably practical.

Recent research has demonstrated that "... many, if not most, HIV-infected individuals will cooperate in notifying at least some of their sex partners of exposure to HIV [and] sex partners are generally receptive to being notified and will seek HIV testing..."³ Positivity rates of S/NSPs of known HIV positive persons are significantly higher than those of the general at-risk population. In New Jersey, where approximately 1,000 individuals are contacted by the Notification Assistance Program each year, there is about a 15 percent HIV seropositivity rate among partners located. In Alaska, about 17 percent of all individuals newly diagnosed with HIV or AIDS were identified through PCRS activities.⁴ In California HIV counseling and testing sites, approximately 1.2 to 1.4 percent of all tests are positive. Infection rates may be as high as 3 to 5 percent when reviewing data for specific high-risk testers.⁵ The advantages of targeting persons at greatest risk of exposure are clearly demonstrated when comparing the serostatus of known partners to those of other high-risk persons.

In practice, PCRS providers have many success stories to share. Anecdotally, counselors who have located exposed partners can attest that their clients have been very satisfied with the quality of the service provided them. For example, a pregnant woman recently named as a partner was contacted by a trained professional and subsequently tested positive. She chose to begin preventive treatment to protect her unborn child and credits the PCRS intervention for saving the life of her baby who is virus-free. Another account involves a partner who was named by a newly infected person. The partner subsequently tested positive also and was immediately enrolled in a HIV specialty clinic. In addition to facilitating the newly infected partner's referral-to-treatment, through HIV prevention counseling and risk reduction planning provided to both the original client and the partner, the PCRS intervention may have interrupted transmission to either person's future partners.

The estimated cost of treating one person with three or four HIV drugs is over \$17,000 per year.⁶ Because HIV positive persons are living longer, there is financial as well as personal justification for intervening in the spread of HIV through the application of routine, standardized PCRS activities. In addition to facilitating early detection of infection and referral-to-treatment, today's PCRS providers receive greater acceptance among HIV care and prevention providers. PCRS providers are given expert training to enhance their counseling and field notification skills and are encouraged by greater HIV/STD collaboration at federal, state and local levels.

In terms of primary prevention, the greatest benefit of PCRS involves working with HIV negative partners. PCRS incorporates a full array of services to assure that these partners have resources to support them in remaining uninfected. Although averting transmission is virtually impossible to measure, scientific and therapeutic interventions now available have proven successful. Some of these have included: 1) maintaining ongoing follow-up with HIV negative partners; 2) referring HIV positive partners to early care; 3) referring sero-discordant couples identified through PCRS efforts to ongoing counseling and support services; 4) providing easy access to medical evaluations for STDs, tuberculosis (TB), and hepatitis; and 5) offering free condoms, risk/harm reduction planning services and personalized education on an ongoing basis. These and other services contribute to the value of HIV partner services as an essential adjunct to a comprehensive and coordinated HIV prevention and referral-to-care effort.

PCRS in the Future

"If we are to maximize their potential for preventing the spread of HIV and effectively address their complexities and controversies, partner notification programs of the future will require specially trained, multidisciplinary professional teams with fully functional quality assurance and evaluation systems that work closely with infected and affected communities."

-West and Stark, "Partner Notification for HIV prevention: A Critical Reexamination,"
AIDS Education and Prevention, 9, Supplement B, 1997

Training for public health providers has been and will continue to be a primary focus of DHS/OA PCRS Program activities. Two PCRS courses that build skills in partner elicitation are currently offered to public health HIV and STD program staff. Plans to develop additional courses are under way. An advanced course for trained PCRS elicitors has been recently offered. The training experience is further enhanced by ongoing direct technical assistance in a pilot project involving five local health jurisdictions. Plans to provide technical assistance to all local health departments as well as the state's larger private and community-based medical community are currently being designed. Expanding services to the private sector outside public health arenas will take into account the need to develop and deliver specialized training to medical providers and ancillary staff.

DHS/OA is currently piloting a PCRS data collection and reporting system that is anticipated for statewide launch during fiscal year 2000/2001. Thorough and accurate reporting of confidential data will provide support to continue and expand funding resources and will enable the state health department to measure the quality of local

program efforts. As PCRS is utilized by more and more clients, PCRS specialists or program coordinators will be involved in routine, standardized service evaluations that will identify strengths and weaknesses in local staff and operations. DHS/OA plans to conduct a statewide PCRS evaluation along with a major California university to establish outcome measures of effectiveness.

It is anticipated that, once the larger medical community is aware of and becomes reliant upon local health departments to provide PCRS services, requests for PCRS assistance may exceed local program resources and abilities to respond in a timely manner. Increased demand and increased funding could result in the assignment of additional staff to local HIV PCRS activities on a full-time basis.

The state HIV PCRS program will be successful if, by providing training, guidance, and personnel, PCRS consultation becomes a standard of care for all HIV positive clients and is routinely and appropriately offered in all public, private, and community-based HIV care, prevention and surveillance programs.

DHS/OA HIV PCRS Mission Statement

1. To interrupt the spread of HIV by providing information, counseling and resources to HIV positive persons that will encourage them to notify their potentially exposed sex and/or needle-sharing partners (S/NSP) of their potential risk for HIV infection, either directly or through provider-assisted methods.
2. To assure that notified partners are offered appropriate counseling, support, referrals and medical follow-up such as HIV antibody testing, additional counseling and, if positive, subsequent medical evaluation, treatment, counseling and referral to other services as needed.
3. To assure that persons with HIV are offered client-centered counseling to negotiate a personalized risk-reduction plan that includes behavioral strategies and biological motivators⁷ to minimize the likelihood of future exposure of or transmission to uninfected partners.
4. To outreach to public and private medical practitioners such as community-based medical programs, other health department clinics, drug treatment programs, and private medical practitioners. Assistance to these persons can be either direct (conducting PCRS on behalf of physicians) or indirect (offering training and support to staff in eliciting partner names).

DHS/OA HIV PCRS Program Activities

1. To assist local health jurisdictions (LHJ) in developing formal HIV PCRS Programs or local PCRS systems of referral that offer HIV PCRS at no charge to all persons with confirmed and verifiable HIV diagnoses, regardless of where or how they learned their HIV status. At minimum, to assure that LHJs identify key staff who will facilitate a referral of HIV positive persons to an experienced PCRS provider.
2. To train HIV prevention providers in how to best engage HIV positive clients in a discussion about their S/NSP's need to know and to initiate appropriate partner interventions whenever possible.
3. To ensure that HIV testing, treatments and other public health services are never made contingent upon a client's willingness to participate in HIV PCRS, including naming partners, notifying partners, or discussing partner needs. This is also true for notified partners who, for instance, may refuse HIV testing but accept referrals to other counseling services.
4. To assist local PCRS programs/specialists in providing both immediate and follow-up support to HIV positive persons and their partners which would include, at minimum, risk/harm reduction counseling, crisis referrals, medical referrals, and additional counseling sessions.
5. To encourage local programs to develop referral agreements with public and private medical and psycho-social service providers to link HIV-exposed persons to additional services to assist them in making informed choices about their own health care.⁸
6. To offer PCRS technical support and other related assistance to providers in community-based medical programs, other health department clinics, drug treatment programs, other public programs, and private medical practices.
7. To ensure that PCRS activities meet the disclosure and confidentiality conditions stipulated in California Health and Safety Code Section 121015.
8. To provide specific policy and procedures to be followed in the event that a physician or surgeon contacts a local health officer to request that a partner be notified of his/her exposure.
9. To encourage local PCRS programs/specialists to offer support to non-exposed family members and significant others if resources allow. Support can include: assistance in disclosing serostatus, referral to professional counseling services, written educational information, and HIV counseling and testing as appropriate.

II.

STATE AND LOCAL PARTNERSHIPS

The State gives form to PCRS. Program design and structure are modeled through training, written guidance, standards of service delivery and on-site and technical assistance.

The Local Health Jurisdiction becomes the substance of PCRS. How the community perceives the value of this service is directly correlated to the local program's ability to follow state guidelines and, at the same time, give input to the development of useful state policy.

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The Role of DHS/OA

California Health and Safety Code Section 100119 designates OA as the lead agency within the State responsible for coordinating State programs, services, and activities relating to HIV, AIDS, and AIDS-related conditions. The statute recognizes that other State agencies and departments conduct HIV-related programs and stresses the importance of coordination of HIV efforts. DHS/OA is the administrative arm of the state HIV/AIDS program. Adherence to state laws and regulations, providing funding for local program development, and offering technical assistance in the implementation of local policy and procedures are all major responsibilities of this office. DHS/OA also oversees the delivery of all HIV-related activities in California and is the sole funding agent of the HIV PCRS program.

Effective January 1996, DHS/OA was mandated by federal legislation to "... take administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to [HIV] and should seek testing."⁹ In November 1996, DHS/OA initiated a series of collaborative meetings with the Centers for Disease Control and Prevention (CDC), the California Sexually Transmitted Disease (STD) Control Branch, Program Operations Unit and STD/HIV Prevention Training Center (STD/HIV PTC), and the San Francisco and Los Angeles HIV and STD Programs. In addition to satisfying the new federal mandate, a main objective of these meetings was to develop consensus regarding HIV PCRS policies, procedures and practices for the State. Two other outcomes of the "State Guidelines Committee" meetings were the coining of the name "HIV PCRS" and the development of the 1998 CDC HIV PCRS Guidance.

The Role of the STD Control Branch

During fiscal year (FY) 1997/98, the DHS/OA redirected \$500,000 of state General Fund to execute an interoffice agreement with the DHS/Division of Communicable Disease Control, STD Control Branch, STD/HIV Prevention Training Center (STD/HIV PTC) for the development and delivery of HIV PCRS training. By the end of the first eighteen months of this contract, DHS/OA and STD/HIV PTC program representatives and trainers developed three training curricula and trained 180 HIV and STD supervisors, approximately 180 HIV prevention staff, and 120 STD staff.

STD/HIV PTC trainers are actively involved in the evaluation of the training courses, in providing technical assistance to local and state PCRS staff, and in assisting local PCRS programs/specialists in building the capacity to respond to the needs of their diverse communities. To schedule staff for PCRS training, a HIV or STD Program Coordinator may contact the STD/HIV PTC PCRS Training Program by calling (510) 883-6600.

Also during FY 97/98, the DHS/OA began planning with the STD Control, Program Operations Unit to establish local PCRS sites in five health jurisdictions with significant HIV and STD incidence, in both rural and urban regions.¹⁰ In May 1999, five PCRS

demonstration projects were launched in the City of Long Beach and the Counties of Sacramento, Alameda, Kern and San Diego. Utilizing federal HIV prevention funds, experienced field consultants have been placed in each jurisdiction to liaison with local, inter-jurisdictional, state and federal agencies. The consultants' primary responsibilities are to develop, support and expand HIV PCRS activities in the local project areas.

As a result of direct state involvement, PCRS activities are well underway in these project jurisdictions. Consultants are involved in such activities as: outreach to private and public medical providers and local planning boards; elicitation, notification, counseling and referral of partners to HIV testing and other appropriate services; and collection, reporting and analysis of HIV PCRS data. Successful project activities will promote the advancement of other DHS/OA HIV prevention activities by:

- demonstrating the most effective methods of working with persons at highest risk of HIV exposure;
- offering new support services to HIV providers; and
- providing valuable lessons learned to community planning boards, counseling and testing providers, early care clinics and risk reduction specialists.

The demonstration projects are being continually monitored for program effectiveness and potential for statewide replication.

The Role of the Local HIV PCRS Program

Local HIV PCRS Programs or specialists are responsible for carrying out partner interventions. All services related to HIV prevention, care and treatment – including the routine provision of PCRS – should be made readily available to all HIV positive clients. Local health departments should establish a PCRS Coordinator or contact person who will be responsible for the administration/delegation of local partner services. This person should work with HIV/AIDS surveillance, care and prevention providers, the local STD program, and the community planning board to develop PCRS program protocol that is consistent with DHS/OA and CDC policies.

Local PCRS Programs or specialists must assure that all staff who will have direct contact with HIV positive persons receive adequate partner counseling training provided by the STD/HIV PTC. Any professional or para-professional who counsels in a test site, provides HIV/AIDS case management or other HIV counseling, or who may contact a person who was diagnosed and reported with AIDS (such as surveillance staff) is eligible for the STD/HIV PTC training. The local PCRS coordinator should be directly involved in the prioritization of appropriate staff for training.

It is strongly recommended that local programs report directly to DHS/OA HIV PCRS Program staff any unusual circumstances that may occur as a result of a PCRS intervention. Local PCRS providers are accountable to their clients, to their own administrators and to the State Department of Health. It is the onus of local programs to ensure that clients are offered PCRS as a voluntary service and that strict confidentiality

is maintained for all aspects of HIV PCRS activities, including record-keeping processes and reporting of epidemiological and statistical information.¹¹

III.

FUNDING REQUIREMENTS RELATED TO PCRS

“The Secretary of Health and Human Services shall not make a grant under part B of title XXVI of the Public Health service Act (42 U.S.C. 300ff – 21 et seq) to any State unless such State takes administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to the human immunodeficiency virus and should seek testing.”

-Ryan White Care Act, Part B, Title II, 5/20/96

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HIV Programs Receiving Ryan White Title II Funds

Federal law requires that any health department receiving Ryan White Care Act (RWCA) Title II funds take action to ensure that a good faith attempt is made to inform spouses of HIV positive persons of their risk. According to this legislation, “marital spouses” are defined as any past or present legally married partner within ten years of the diagnosis of HIV infection.¹² Recommendations for identifying, notifying, counseling, and referring spouses are incorporated throughout this document. They are indistinguishable from general PCRS standards that offer services to all at-risk sex and needle-sharing partners (S/NSP). The following DHS/OA funded programs and local health program activities are strongly encouraged to comply with the RWCA requirements and DHS/OA policy and standards.

Establishment of a Local HIV PCRS Program

Each local health jurisdiction should establish a formal PCRS program that (or designate a senior staff administrator who) will be responsible to receive and process all local and out of jurisdictional requests for elicitation and field notification, counseling, referral, and follow-up of partners.

In order to assure that a good faith effort is universally made to notify partners of HIV positive persons, local health jurisdictions must be capable of providing partner elicitation and notification services as needed and appropriately report PCRS data to DHS/OA. Local PCRS programs/specialists should develop site-specific procedures that honor client confidentiality and voluntary participation as well as uphold all required DHS/OA policies as stated herein. The DHS/OA HIV PCRS Program is available to assist local jurisdictions in the development of local protocol and facilitation of field follow-up.

DHS/OA-Funded HIV Prevention, Care and Treatment Programs

Any HIV provider or agency that receives funds from DHS/OA to provide services to HIV positive persons must offer HIV PCRS through their agency or through a referral to the local health jurisdiction’s PCRS program or designated contact. Mechanisms must be in place to ensure that any individual requesting PCRS assistance receives, at minimum, a direct referral to a trained PCRS provider.

If a local program is unable to conduct PCRS on behalf of its clientele, then a direct referral to a state STD or HIV PCRS specialist must be immediately facilitated. All staff who work with HIV positive clients must have written information that provides the contact name, address, and phone number of the closest PCRS trained specialist.

Providers That Are Not Funded By DHS/OA or RWCA

In non-DHS/OA-funded facilities, HIV PCRS should be provided at whatever point during the continuum of care seems most appropriate. PCRS discussions may occur in a variety of settings such as primary care clinics, hospital emergency departments, social services settings, or private medical practices. Local health jurisdictions are encouraged to

outreach to all HIV specialty providers to facilitate the offer of PCRS assistance and refer clients who accept the offer to the local PCRS specialist or program.

Program Recommendations

1. HIV Counseling and Testing

Risk Assessment Counseling Session: Whenever it is appropriate, HIV C&T counselors should present the concept of HIV PCRS to every testing client, initially, during the risk assessment session (pre-test). A simple statement informing the client of the availability of the service would suffice. There is no need to elicit partner names during the risk assessment session. Any pertinent partner information¹³ that is elicited should be documented in the “counselor notes” section of the HIV Counseling Information Form (CIF).¹⁴ If a client states that he or she is currently married or has been married within the past ten years, this information should be documented as well. For more information regarding the implementation of HIV PCRS in anonymous (including Alternative Test Sites) and confidential C&T facilities, please refer to Section IV, “PCRS Implementation in HIV Counseling and Testing Programs.”

Positive Test Result Disclosure Session: For clients who test positive and are emotionally prepared to talk about partner referrals during the positive result disclosure session (post-test), the PCRS elicitation session can be readily incorporated. Some circumstances may include clients who:

- wish to discuss partners with the C&T counselor and no one else;
- can not be referred to a confidential provider who can offer PCRS; or,
- plan to leave the health jurisdiction without having other scheduled medical visits before departure.

If a client is unable or unwilling to discuss PCRS during a positive disclosure session, the C&T counselor should attempt to reschedule a follow-up appointment. Making a sound referral to a medical system of care, such as an EIP, enhanced counseling or AIDS case management program where PCRS needs can be reassessed is also important.

HIV C&T programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialists or programs for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.¹⁵

2. Outreach and Mobile Clinic Testing Services

HIV PCRS activities can be implemented in outreach and mobile clinic services if counseling staff is adequately trained in elicitation skills. Because of possible special client needs about confidentiality, trust must be emphasized for HIV positive clients served by outreach or tested in mobile clinics.

Outreach staff can also be very helpful to field staff who need to notify and counsel partners of outreach clients. Experience has shown that some persons will not open doors or identify themselves to strangers, which poses a real impediment to locating named partners. Outreach staff, however, may not be strangers. In fact, many are peers and ex-members of social networks formerly involved with clients of outreach services. Therefore, the outreach worker can pave the way for field staff to meet exposed partners. Because of liability protections, only designated, trained field specialists who are on staff with the local health jurisdiction, such as DIS and public health nurses, can notify persons of their exposure; however, it is very appropriate for the DIS to “team” with an outreach worker in the field in order to find the named partner.¹⁶

DHS/OA is developing policies and procedures for Outreach and Mobile Clinic Testing activities. Greater detail and specificity regarding PCRS activities in these settings will be addressed in future versions of this guidance document.¹⁷

HIV outreach and mobile clinic programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialists or programs for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.¹⁸

3. HIV Transmission Prevention Project (HTPP)

Currently operating in 11 local health departments, HTPP is a demonstration project funded by the Centers for Disease Control and DHS/OA that is based upon the CDC’s Prevention Case Management (PCM) model. PCM is a client-centered HIV prevention activity designed to promote the adoption of HIV risk reduction behaviors by persons with multiple, complex problems and risk-reduction needs. Guided by the PCM model, HTPP is intended for both HIV positive and HIV-negative persons at greatest risk of transmitting or acquiring HIV -- persons whose needs are not being effectively served by traditional case management systems, and whose behavior is not influenced by less intensive interventions. HTPP integrates a number of therapeutic techniques such as short-term, solution-focused counseling strategies, behavior change theory and practice, and harm reduction theory and practice. HTPP staff will work with clients to identify specific behaviors, situations, or circumstances that prevent or inhibit their ability to engage in effective risk reduction, and will work together to develop a personalized risk reduction plan for each client.

HTPP and PCRS efforts can readily complement one another. The high-risk, high-need clients targeted by HTPP may benefit from a referral to PCRS. HTPP staff are able to develop long-term relationships with their clients and are able to make an individualized assessment as to when and how to introduce disclosure issues and the possibility of utilizing PCRS. Conversely, PCRS clients who meet eligibility criteria for HTPP may be referred to that program for assistance in developing specific risk reduction strategies. HTPP and PCRS providers should understand the respective roles in HIV prevention services that both programs play. Managers should promote

staff interaction and involve each other in the development of local protocol, specifically with regard to referral linkages.

HTPP programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialists or programs for assistance in conducting PCRS for their clients and named partners. If a is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.¹⁹

4. Early Intervention Program (EIP)

Interrupting the transmission of HIV is one of the primary goals of the Early Intervention Program, and DHS/OA EIP protocols call for informing all EIP clients of the availability of HIV PCRS. EIP sites are required to provide clients with regular psychosocial assessments and brief counseling services, health education, and risk reduction information and support. Because of this comprehensive model of service provision and case management, notification and referral of sexual and needle-sharing partners is naturally interwoven throughout the range of EIP services. EIP staff are able to develop ongoing relationships with their clients. The long-term relationship between client and provider enables EIP staff to use their own clinical judgement to determine the most appropriate point at which to introduce or re-introduce the possibility of partner services. Disclosure issues may be worked into a client's Individual Service Plan, and the case manager then supports the client in following through with any disclosure, notification, or follow-up. Depending upon the wishes of the client, disclosure may be handled by the client alone; with the support of their case manager; in counseling sessions with the case manager, client, and S/NSPs; or the client may choose to be referred to PCRS staff for assistance.

All EIP staff members who have regular client contact are encouraged to participate in the PCRS training in order to strengthen their skills in this area. EIP sites should offer PCRS on-site or should be aware of the local PCRS specialist or program contact to facilitate referrals to partner counseling services. Notes documenting discussion of disclosure issues and/or PCRS should be recorded in each client's chart. Finally, EIP staff should remember that use of PCRS and notification of S/NSP of their possible exposure to HIV is *voluntary*, not required, and every effort must be taken to protect the confidentiality of EIP clients who choose to utilize PCRS assistance.

EIP programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialists or programs for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.²⁰

5. AIDS Case Management (CMP) and Medi-Cal Waiver Programs (MCWP):

Nurse Case Managers and Social Work Case Managers in the AIDS Case Management Program have ongoing relationships with clients with symptomatic HIV or AIDS. Case managers do in-depth nursing and psychosocial assessments at

least every 60 days with their clients. They have a unique opportunity to discuss ongoing risk and PCRS. PCRS is also implemented similarly in the Medi-Cal Waiver Program, which provides services to persons with mid- to late-stage AIDS.

The case managers discuss the implications of S/NSP referral with the client at the time of the initial assessment. If a client is unwilling or unable to discuss partners at this initial visit, the topic is approached at a later visit(s) when possibly a greater level of confidence has developed.

CMP and MCWP programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialists or programs for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.²¹

6. Consortia Programs

The Local HIV Care Consortia Program supports the planning, development, and delivery of comprehensive outpatient and support services for people with HIV/AIDS and their families. Contracts with local health departments or community-based organizations include language requiring that clients be informed of the availability of HIV Partner Counseling and Referral (PCRS) services. All subcontracts with HIV/AIDS service providers are required to include similar language. Service providers must offer HIV PCRS through their organization or a referral to the local health jurisdiction's PCRS specialist or program.

HIV Care Consortia programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialist or program for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.²²

7. HIV/AIDS Surveillance Programs

California State law requires doctors, hospitals, and other health care providers to report newly diagnosed AIDS cases to local HIV/AIDS surveillance programs. Licensed health care providers often have ongoing relationships and good rapport with their patients and may be able to supply information and request follow-up of specific partners at the time of the report. Although not considered to be service-oriented programs, local AIDS surveillance programs have at least four opportunities for involvement in HIV PCRS.

1. One opportunity involves those cases being reported with no identified risk (NIR). An NIR report requires a special investigation to identify the mode of transmission by which HIV infection occurred. If risk identification cannot be achieved by reviewing medical charts or by contacting the reporting provider, the surveillance worker may attempt to speak privately with the infected person to elicit personal risk information or the risk histories of his/her sex partners. This confidential discussion

can sometimes require follow-up with identified sex partner(s) in an attempt to determine the partner's serostatus and risk of HIV.

2. Another surveillance/PCRS opportunity would involve the reporting of unusual cases or strains of HIV such as HIV 2. Since HIV 2 is uncommon in the United States and is associated with high rates of transmission among sexually active persons in West Africa, these cases invariably include an effort to determine the HIV status and viral genotype of the partner(s). HIV-2 is also associated with high rates of heterosexual transmission of HIV.²³
3. If the reporting physician requests that the surveillance program conduct partner services on his/her behalf, there is need for surveillance program staff to be familiar with local PCRS procedures. In these cases, the physician should obtain consent for partner follow-up from the original client and pass the responsibility on to the health department.²⁴
4. Lastly, HIV reporting health jurisdictions often contact state and local AIDS Surveillance programs for follow-up of partners to HIV positive reported cases.

In smaller health departments, surveillance staff may have multiple program responsibilities, such as working in confidential or anonymous test site programs or case management services. Because of the ability for direct linkages between service programs, rural surveillance programs may routinely contact reporting physicians to obtain permission to speak with the patient.

HIV surveillance programs that have not sent staff to the three day PCRS elicitation training conducted by the STD/HIV PTC should contact their respective PCRS specialist or program for assistance in conducting PCRS for their clients and named partners. If a PCRS specialist or program is not available in the local jurisdiction, the STD Regional Field Office should be able to provide support.²⁵

IV.

PCRS IMPLEMENTATION IN HIV COUNSELING AND TESTING VENUES

“Some clients aren’t ready to talk about partners when they first learn their own serostatus, but other clients think of their partner first. The first question they might ask is: “What about my husband?” or, “How will I tell my partner?”

-quote from an ATS counselor, 1999

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HIV Counseling and Testing (C&T) Service Venues

In DHS/OA-funded HIV C&T venues that provide anonymous or confidential testing services, including the state-mandated alternative test site (ATS) program, the names of sex and needle-sharing partners (S/NSP) may be elicited by a PCRS-trained HIV test counselor without sacrificing the anonymity or confidentiality of the original client (OC). Informed consent for PCRS must be obtained verbally in anonymous testing venues.

Confidential HIV C&T services include any testing service wherein the provider knows a client's name or other identifying information. For all confidential C&T programs, it is strongly recommended that clients provide written consent for PCRS.²⁶ A copy of the consent form must be retained in a confidential, locked file.

Ideally, clients who test HIV positive in anonymous test sites will be referred to confidential systems of care such as an EIP program, other case management or PCRS specialist or program for partner services. If the referral cannot be made in a timely fashion or if the client chooses to discuss partners on the spot, anonymous and confidential test counselors should be prepared to spend extended time with the client during the result disclosure (post-test) session. Identifying the names of partners presents no inherent breach of the client's anonymity.

If a test counselor is not trained or prepared to conduct PCRS, the client should be immediately referred to a trained PCRS counselor.

Written consent for notification of partners is recommended in confidential settings including C&T, EIP, CMP, Surveillance or in any HIV service program wherein the OC's name is known to the provider. As is true of all medical and counseling forms, confidential and secure record keeping procedures must be implemented.

Documenting a PCRS Referral on the Counseling Information Form

In order to be reimbursed for the referral, whenever an OC is referred from a HIV C&T site to a PCRS specialist/program, the referral must be documented on the counseling information form (CIF). If the test counselor elicits partner name and locating information, the counselor must enter a "1" by the "Partner/spousal notification" option in the Disclosure Section of the "Referral" box on the CIF.²⁷ If the discussion of PCRS leads to a need to refer the client to a PCRS specialist/program, the "Partner/spousal notification" option in the Disclosure Section of the "Referral Box" should be checked with a "2 or 3," whichever is appropriate. Additional notes may be written into either the "Short- and Long-Term Risk Reduction Plan" or the "Counselor Notes" sections of the CIF, as appropriate.

When disclosing HIV positive results to a client, checking the "Partner/spousal notification" option in the Referral Box on the CIF will provide documentation that PCRS

was offered and, according to federal law, a “good faith effort” to notify spouses was made, whether or not the client elected to notify a partner via client- or provider-assisted referral options.

If the positive disclosure counselor: **1)** elicits partner information for PCRS follow-up, **2)** conducts a dual-referral, or **3)** coaches the OC in ways to self disclose, the “Partner/spousal notification” referral box should indicate that PCRS was the **primary referral** by entering a “1.” Even though there may be no need to “refer” the client to a different PCRS provider, the PCRS elicitation component of the disclosure session should be considered a separate intervention. If the counselor refers the client elsewhere to receive PCRS counseling, the counselor should mark a “2” or “3” to indicate that a discussion of partners occurred during a positive disclosure session and the PCRS referral was one of other needs identified by the OC. If PCRS was discussed, however, the client indicated that he/she was not at all interested in discussing partner referral needs, it will be important to document the “offer” of PCRS in the “Counselor Notes” Section of the CIF. The pilot data collection process includes forms that document the offer of PCRS and the OC’s decision regarding that offer.

HIV PCRS discussions should be documented in the Counselor Notes Section, Short/Long Term Risk Reduction Plan Section, or the OC’s medical chart, if available. In most cases, documentation should be kept to simple, direct notations such as:

- PCRS accepted, partners elicited.
- PCRS accepted, referral made to _____ (provider).
- PCRS discussed and postponed until next appointment on _____ (date)
- PCRS discussed. Client will consider/call back.
- PCRS discussed. Client not interested.
- PCRS discussed. Client has already notified partner(s).
- Client not offered PCRS. Reason, _____.

Whenever a client is willing to discuss partner referral options with another provider or at a different appointment, the name of the other provider or date of the next appointment should be recorded in the chart for follow-up purposes.

No-Show Client Follow-Up

In the event that a HIV positive client (or a client whose test result is inconclusive) fails to return to the test site for result disclosure and counseling services, the confidential testing site is encouraged to attempt to contact the no-show client and reschedule. DHS/OA-funded confidential C&T sites are reimbursed \$25.00 for making an attempt. Should the site staff be unsuccessful in reaching the client, initiating a no-show client follow-up utilizing the expertise of a PCRS program specialist is very appropriate. In order to receive the additional stipend, however, test site staff must attempt to contact the client first. Simply referring the no-show client information to a PCRS specialist does not qualify the C&T site for additional funding.

In 1997, DHS/OA identified additional reimbursements to compensate local HIV C&T sites for taking extra measures to reduce the client no-show rate, especially when the client's test result is HIV positive or inconclusive. Some confidential sites maintain medical charts that have locating information (e.g., addresses) for reaching the client. C&T site staff should attempt to reach the client by telephone to reschedule, if the number is known.²⁸ If telephone contact is not successful, a letter may be appropriate or a field visit can be arranged through the PCRS specialist or program. High-risk negative no-show client follow-up is the responsibility of the HIV C&T program. The services of the PCRS staff only should be directed toward known HIV positive and indeterminate client follow-ups.

There have been situations in which an HIV positive person is not informed of his or her HIV status within the private and community-based medical system. Patients have been known to leave hospitals against medical advice. Patients may not return phone calls from their private physicians. Patients may move without leaving forwarding addresses. Any of these situations could potentially involve an HIV positive person who is not aware of his/her diagnosis. If physicians contact the local health department to request assistance in notifying patients of their own HIV test result, and if the test result is a confirmed positive or inconclusive, HIV PCRS field specialists should provide the follow-up.

Depending on client preference and local testing protocol, the field worker can locate the positive client and either conduct a result disclosure session in the field or schedule a return appointment to the C&T clinic. Fieldwork processes for no-show client follow-up are the same as those for PCRS partner follow-up. The same care is taken to maintain client confidentiality. HIV prevention counseling and risk/harm reduction planning is immediately offered. PCRS is introduced and conducted if appropriate.

C&T Program Recommendations

1. Encourage OCs to Keep in Contact

The post disclosure counseling session is a very appropriate time for counselors to discuss PCRS or other issues with HIV positive clients. Many HIV test counselors ask their positive clients to call back within one week to "check in." Clients who test in an anonymous site can use code names or ID numbers to retain their anonymity. This additional interaction with the counselor can offer an opportunity to revisit partner issues as well as help assure that the client is accessing other needed services. Many clients will call and will appreciate the chance to work with their counselors on additional concerns. C&T counselors can encourage clients to contact the local PCRS specialist or program or introduce them to a PCRS specialist at this time if possible.

2. Special Considerations for Confidentiality in the Field²⁹

As is true of anonymous test clients, confidentiality and protecting the OC's identity is critical to PCRS success. Oftentimes, an HIV test client has a partner who has

been tested in the past at the same facility. To avoid the possibility that partners who are initiated for field follow-up will associate a field worker with an HIV test site, the HIV test counselor should involve the OC in determining the best date and time for the field visit. This information and any other special concerns must be documented on the CIF or other blank sheet of paper that will be transferred to the field worker. Another safeguard would be to have a STD field worker who is not associated with the HIV program conduct the notification. If necessary, field assistance could be requested from the Regional STD Field Operations Unit that may be able to dispatch a field specialist from a different health jurisdiction.³⁰

3. Counselor Support

It should also be noted that HIV C&T counselors may have personal issues or opposition to PCRS they need to process, especially ATS counselors. State-mandated, free, anonymous testing has always been a “sacrosanct” service, devoid of names and affiliations, and set apart from all other services available in public health, including confidential HIV testing. Counselors have honored the ATS as inviolate – a safe place for any client, a place where clients have been allowed to reveal only what they chose to reveal, with little interference from the counselors. THIS POLICY HAS NOT CHANGED. However, there may be a perceived violation of traditional practice to which some counselors may be challenged to adapt.

ATS supervisors should address counselor concerns on an individual basis, in staff meetings, and/or with written policy. The benefits of HIV PCRS to both clients and partners and the voluntary nature of this service can be emphasized to work through counselor reservations. If a counselor does not feel comfortable with offering PCRS, he/she should not attempt to provide the service and should be supported in asking someone else to “step in” and serve the client.

V.

WORKING WITH THE HIV POSITIVE CLIENT

“Although it is certainly not the only important factor in optimizing the benefits of a partner-notification program, the appropriate selection and training of counselors appears critical for communities attempting to establish their own partner-notification programs.”

-Randolph F. Wykoff, M.D., M.P.H., U.S. Food and Drug Administration and
Jeffrey Jones, M.D., M.P.H., South Carolina Dept. of Health and Environmental Control

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Overview

HIV positive persons are served by a variety of public and private medical practitioners (C&T, EIP, Outreach, CMP, CBO, private physicians). Assistance in notifying and referring sex and needle-sharing partners (S/NSP) should be routinely offered to these clients in all service venues. If PCRS is accepted or requested, the client should be provided immediate counseling or referred to a PCRS specialist or program. CDC PCRS standards primarily emphasize the need to offer PCRS to clients who test positive in C&T clinics. While this service type is an excellent place to begin the discussion, because many clients first learn of their HIV status in this setting, it is not the only service that can easily accommodate partner counseling. Many care and treatment programs work with HIV infected persons who either have never been offered assistance in PCRS or who have recent partners whom they would gladly accept help in notifying. It is for this reason that the following standards and recommendations address elicitation counseling in test sites as well as all other service venues that deliver counseling and care to HIV positive and AIDS-diagnosed persons.

Program Standards for HIV PCRS Elicitation Services

1. Training Requirements

All HIV staff who perform partner elicitation must be current in their DHS/OA HIV Counselor Training certification ³¹ (or other professional counseling licensure) and have successfully completed one of the following courses within two years:

- ♦ ***DHS/OA HIV PCRS Elicitation Training (three-day course)***
- ♦ ***CDC Partner Management Training***
- ♦ ***CDC Introduction to Sexually Transmitted Disease Intervention (ISTDI) ³²***

Disease intervention specialists (DIS) who have successfully completed the Introduction to Sexually Transmitted Disease Interventions (ISTDI) course and are currently providing elicitation/notification services in a local health jurisdiction are not required to attend the above classes. However, they should attend the one-day “HIV PCRS Update for DIS” provided by the STD/HIV PTC.

Competent elicitation processes involve a detailed discussion of partners identified to be at risk of exposure. Counselors must have strong listening and focusing skills and must pay close attention to the OC's specific needs and emotional processes. Experience has shown that the more accurate and detailed the identifying and locating information, the more quickly partners will be located, and consequently the more likely OC and partner confidentiality can be maintained. Protecting the confidentiality of partners is as important as protecting the privacy of the OC.

No one can be forced to provide the names of partners. Counselors must develop trust with their clients and be extremely confident in delivering the PCRS messages. While attending to the OC's process, elicitors must obtain as much information as possible to ensure that the field worker (who attempts to contact the named partner)

is capable of locating the right person expeditiously. To assure that accurate and complete identifying and locating information is consistently obtained by elicitors, the training courses offered are mandatory and provided at no charge to persons conducting DHS/OA-funded activities.

Minimum Level of Counselor Skill

At minimum, DHS/OA-funded PCRS elicitors should demonstrate an adequate level of competency in delivering the following messages and services: ³³

- ♦ address main client concerns and answer any questions regarding PCRS;
- ♦ effectively illustrate the benefits/concerns of PCRS to both the OC and the partners;
- ♦ describe all partner referral options accurately and objectively;
- ♦ identify and assess for risks that may be encountered (such as violent partner reactions);
- ♦ assist the OC in determining the best method to notify partners, if the OC is ready.
- ♦ describe how partners are notified by the PCRS field staff (provider-referral only methods in the field) and how confidentiality is maintained throughout the process;
- ♦ fully understand and collect adequate locating information for provider-only referral requests; and
- ♦ demonstrate competency in “coaching” clients in self-referral of partners.

2. Urgency Clause

Partner identifying and locating information must be immediately forwarded to the local PCRS notification program, such as the STD Control Unit or other designated staff.

Once the elicitor obtains complete information about any partners the OC selects to be provider-notified, the elicitor’s notes should be immediately transcribed onto the two data tools: the Original Client Information Form and the Partner Information Form. It is extremely important that the elicitor take notes on a blank sheet of paper. Official forms must be kept out of the client’s view. More information about these forms is available in the Data Reporting section of this manual and line by line instructions for completing the forms are provided in the Appendix.

Once the forms are completed carefully and legibly, the information is then forwarded to the local PCRS notification program, such as the STD Control Unit or other designated staff. Efforts to contact the named partner must be made within 24 hours of the initial elicitation session because rapid follow-up is critical to preventing further spread of the virus.

3. Voluntary Service

HIV and other public health services must never be made contingent upon an HIV positive client's willingness to participate in a PCRS counseling session.

How well PCRS elicitors foster an atmosphere of trust, respect and rapport with HIV positive clients will significantly impact the success of local PCRS efforts. The foundation of all HIV PCRS sessions is built upon the client-centered counseling approach. Therefore, all partner information is voluntarily provided by the OC.

4. Informed Consent

Because PCRS is a voluntary service, informed consent is implied once the OC divulges names and locating information for partner(s).

California Health and Safety Codes do not require that a written consent be obtained from the OC in advance of the partner elicitation process, however, DHS/OA strongly recommends that local programs obtain written consent from all clients for whom PCRS elicitation and notification will be provided. Clients who do not wish to divulge their names (such as ATS clients) should be able to retain their anonymity if they so choose.

Developing a Partner-Specific Referral Plan

HIV PCRS counselors must be proficient in describing all partner referral (notification) options to HIV positive clients. Counselors must adequately inform the OC of the possible benefits and concerns of each option and objectively assist the OC in deciding if, how and when each partner is to be notified. This process is described as partner referral planning.

Beyond addressing the immediate needs or concerns of the OC regarding the process of informing partners, a principal focus of counseling HIV positive persons about their partner's need-to-know is to help them determine who to tell and how to tell them. Should the OC decide that partner(s) need to know, the PCRS counselor will work with the OC to develop a partner-specific referral plan that will best serve the needs of the client, the partner(s), and public health. Elicitors must be familiar with and be able to effectively communicate some of the "benefits and risks" of each referral method. A chart listing some commonly expressed examples of benefits and concerns is provided in the Appendix.

Counselors must present options to OCs in an objective manner, however, it may be appropriate to recommend one option over another based upon the specific circumstances and needs of both the OC and the partner(s).

Suggested Sequence of Questions to Ask OCs Who Opt for PCRS

- "Let's talk about how your partners can learn of their risk."
- "How many partners would need to know?"
- "What are their first names?"
- "Who would you like to tell yourself and who would you like us to tell for you?"

1. Partner Referral Options

Before a client can decide whether or to what extent s/he will voluntarily participate in PCRS, the client must understand that there are a variety of available options regarding **who** will contact partners. There are basically two types of partner referrals: client-referrals and provider-assisted referrals. Client-referrals allow the OC to self-disclose his/her serostatus to a partner(s). The provider-assisted referral generally refers to any referral that could directly involve the PCRS provider, namely: provider-only, dual- or contract-referral. Each option is described below, including typical client circumstances the counselor will want to consider when helping the client choose one method over another. A chart listing the “Benefits and Risks” for each referral type is provided in the Appendix.

a. **Client-Referral**

Oftentimes referred to as “self-referral,” this notification and referral procedure is distinguished by the OC’s direct and sole involvement in notifying a partner of possible exposure. Once the OC discloses his/her HIV status to the partner, the OC should be prepared to answer basic questions about transmission and the meaning of “exposure” and refer the partner to a PCRS provider or other medical provider for HIV counseling.

This referral method is often chosen by an OC who wants to inform a long-term, committed partner. Although limited research exists regarding the effectiveness of this method, clients who want to tell their partners should be encouraged to do so and supported in how to do so.

DHS/OA strongly discourages PCRS providers from coaching or supporting OCs in client-referral methods where domestic or other partner violence (D/PV) is a concern. Section IX describes DHS/OA policy regarding D/PV and HIV PCRS.

Counselor Considerations:

- ◆ Be confident that the client is capable of informing partner(s) of their potential risk and conveying the message that the partner needs to be tested to determine his/her own HIV status.
- ◆ Ask the OC how he/she will tell the partner and offer assistance or “coaching” as needed.
- ◆ Point out to the OC that disclosure of one’s own HIV positive status may have psychological and social ramifications. Assist the OC in determining ways to effectively cope with any negative impact (abandonment, denial, and anger).
- ◆ Assess whether there is risk of violence. If yes, discourage client-referral.
- ◆ Give the OC written information about HIV risk behaviors and testing services and your personal business card to offer the partner.³⁴

b. Dual-Referral

In a confidential and private setting, this method involves the OC disclosing his/her HIV positive status to a partner in the presence of the PCRS counselor. Dual referrals can occur in a variety of settings including anonymous or confidential test sites, a client's home, or any confidential setting that is selected by the OC and agreed to by the PCRS provider. Settings must be confidential and private.

Counselor Considerations:

- ◆ Dual-referrals often occur in C&T facilities when a partner is in the waiting room. They can also occur in other medical and counseling programs.
- ◆ Consider this option if the OC is unable to convey correct information to the partner but wants to be present for the disclosure. If the partner would likely discern the OC's HIV status, dual referral can be a very helpful service.
- ◆ The skill of the PCRS counselor must be adequate to sustain the productivity of a multiple client counseling process.
- ◆ Conduct dual referrals in the office if possible to help assure counseling back up if needed.

c. Provider-only Referral

A very effective method of partner intervention, provider-only referrals protect the anonymity of the OC. The elicitor obtains complete identifying and locating information and client consent necessary to notify, counsel and refer each named partner. The elicitation process involves specific skills and training and, most importantly, the complete trust of the OC. If the OC is confident that his or her name and any other identifying information will never be disclosed to a partner by the field worker, the OC will be more likely to choose provider-only over other methods of referral, especially for past partners and partners who are not well known.

Provider-only referrals can be quite costly to conduct, however research has demonstrated it is the most reliable method of referral.³⁵ The PCRS provider has direct knowledge of the outcome of provider referrals and can document that a "good faith effort" is being made to notify spouses of HIV positive persons. If a trained field specialist conducts the notification, the local health department knows that partners are effectively served with accurate information and sensitive, culturally competent counseling services.

All identifying and locating information elicited is strictly confidential. Once the field intervention is completed, the partner's record is given a disposition (or outcome measure). The data can then be reported anonymously (stripped of all client and partner identifiers) to the DHS/OA HIV PCRS Program. More detail about the pilot data reporting process and the various dispositions for partner follow up is provided in Section VIII, "Data Collection and Reporting."

Counselor Considerations:

- ◆ If the OC's relationship with the partner is estranged, no longer in "good standing," or if the partner lives in another county, state, or country, provider-referral is usually recommended.
- ◆ If the OC is not certain where a partner currently lives, or if other locating information is marginal, a provider-referral may still be successful.³⁶
- ◆ If the OC is concerned about confidentiality, the provider-only method guarantees that the name of the OC will never be disclosed to partners.
- ◆ Although the OC's anonymity is protected, the counselor may wish to prepare the client for various partner reactions such as manipulation, false accusations, anger, blaming. Partners rarely guess accurately who disclosed their names, however, anecdotal reports include stories of partners accusing the OC and the OC feeling forced to "admit." Consequently, the integrity of PCRS is devastated. Elicitors must contact their local field specialists to inquire how to coach their clients should these rare, but real, situations arise.

d. Contract-Referral

When an OC chooses to self-refer partners but there is clear indication that the OC is uncertain about his/her ability to successfully complete the referral, a contract-referral can be proposed. The elicitor must develop a back up plan should the OC's intentions be hindered or abandoned altogether. Contract-referrals involve a verbal agreement between the OC and the elicitor, a specified time frame, and an identified medical provider or C&T facility. The client agrees to a date by which a partner will be notified and referred to services, however the elicitor has the information and consent necessary to conduct a provider-only referral should the OC's efforts be unsuccessful.

The elicitor obtains all necessary identifying and locating information for each partner to be contract-referred and holds the paperwork until the agreed upon "due date." Because the OC and the PCRS elicitor have previously identified a method by which the partner's referral is verified, the elicitor will know whether the contract referral took place.³⁷ If the partner is referred in for counseling and testing or other counseling or medical service by the due date, then the elicitor notes are never initiated for field follow-up. An anonymous data report can be completed and submitted to the DHS/OA.

Verification of a successful referral can include a number of methods, some more creative than others. The range of possibilities can extend from direct involvement of the PCRS specialist to no involvement of the PCRS specialist, from the partner contacting the elicitor directly to the partner's providing written authorization for the PCRS specialist to obtain verification of a private medical visit. One effective way to verify that a partner has been informed of his/her risk in an anonymous service setting is to establish a code name for the partner. This code name will be used by the partner who can then visit the local ATS, public

health testing clinic or otherwise contact the elicitor. If the partner or the OC contacts the PCRS elicitor to verify the completion of a referral, the elicitor can accept the client's word.

Counselor Considerations:

- ◆ If the OC wants to notify a partner, but feels somewhat uncertain about his/her ability to follow through, recommend contract-referral.
- ◆ Work with the OC to identify who to refer and how to disclose. Offer “coaching” as needed.
- ◆ Create a back-up plan should the OC not be able to conduct the notification and referral.
- ◆ Obtain identifying and locating information for each partner to be referred by the OC in case the back-up plan needs to be implemented.
- ◆ Designate a date by which the partner will be referred in for services.
- ◆ Identify a method by which the PCRS provider can verify that the partner received services.
- ◆ Assure the OC understands that provider-only referral will be implemented if the client-referral is not conducted.

2. No Referral

HIV PCRS is a voluntary service. Therefore, “no referral” of partners is a viable option. Elicitors/counselors should remember that, for some clients, this may be the best option. Any discussion of a partner's need-to-know must respect the OC's judgement regarding the potential consequences that may occur as a result of a PCRS intervention. If the counselor assesses that the safety of the OC or the partner is at risk, partner referral should be deferred indefinitely.³⁸ Should the OC fear abandonment, loss of job or need other necessary support, the counselor should attempt to provide solution-oriented referrals to the OC and encourage him or her to call back when/if the situation resolves itself. Finally, the counselor is responsible to clarify any misconceptions the OC may have regarding partner risk or confidentiality, for example, to fully inform the infected client regarding the severity of the partner's need as well as the protection of the OC's personal rights.

Programmatic Recommendations for Elicitation Services

1. Setting Priorities for Reaching Partners

Prioritization of the order in which sex or needle-sharing partners will be contacted is based on client circumstances and individual partner risk. Ideally, all partners should be rapidly notified of their possible exposure, however, population mobility and limited program resources may dictate establishing priorities. A common rule of practice set forth by CDC determines priorities using the following three factors:

- which partners are most likely to already be infected;
- which partners are most likely to become infected; and
- which partners are locatable.

2. Other Factors to Consider when Prioritizing Follow-up Plans

If a client has had more than one partner who is potentially at risk, a variety of factors must be considered when deciding the most appropriate order in which partners will be informed. These can include: documentation of the OC's infectious period, if available; the OC's self disclosure of risk history; multiple or repeated exposures; and the partner's other risks. The following factors also play a significant role in the transmission of HIV:

- a. **Partners of a Recently Infected Client (History of Negative Test Results, Findings from Detuned³⁹ Assays, or Other Evidence of Recent Infection):** Recently infected persons are highly infectious. Partners exposed during this period (usually 4 to 6 weeks) should receive high priority for PCRS.
- b. **Possible Transmission to Others:** Partners, if infected, who are determined to likely transmit HIV to others, must receive high priority. These could include partners who share needles with people other than the OC, partners who have anal or vaginal sex with persons other than the OC,⁴⁰ pregnant women, partners who are in significant relationships with pregnant women other than the OC, and women who have recently given birth.
- c. **Continuing Risk and Multiple Exposure:** Current, recurring, and recent partners are a high priority because of their continuing risk of becoming infected.
- d. **STD History:** History of or current diagnosis of other STD infections in either the OC or partner places a sex partner at increased risk.
- e. **Exposure to HIV-2, Highly Contagious Subtypes of HIV, and Resistant Strains of HIV:** Partners of clients with HIV-2 infections receive high priority because of the rarity of this virus in the U.S. Partners of clients diagnosed with HIV-1 subtype B are at elevated risk due to the virulence of this subtype. Evidence of possible exposure to a strain of HIV that is resistant to antiretroviral therapies (by client-reported HIV drug non-compliance) would also afford partners a high priority.
- f. **Past or Present Marital Exposure:** As dictated by federal law, marital exposure within the ten-year period prior to the client's HIV diagnosis must be carefully considered when prioritizing partners for notification, counseling, and referral.

The Spousal Notification Requirement

Local Health Jurisdictions must consider Public Law 104-146, Section 8[a] of the Ryan White CARE Act Amendments of 1996. This federal funding mandate requires that a good faith effort be made to notify "... any individual which is the marriage partner of a HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10 year period prior to the diagnosis of HIV infection."

Examples of a Good Faith Effort: (provided by CDC)

- ◆ Asking all HIV positive clients if they have a current or past marriage partner within the past 10 years;
- ◆ Notifying these partners of their possible exposure to HIV;
- ◆ Referring them to appropriate prevention services; and,
- ◆ Documenting these efforts.

3. Determining When to Elicit Partner Names

Given the intense emotions often associated with receiving a HIV positive result, the C&T positive disclosure session may not be the most appropriate time to elicit partner names. It can provide a good opportunity to explore client feelings and concerns regarding partner issues and to document significant findings on the CIF (denial, fear of violence, marital status, and willingness to explore later). When clients are not "ready," the C&T counselor should introduce the concept of partner referral and briefly explain the various referral options available, support the client around his/her immediate needs, and leave the door "open" to revisit PCRS at another time.

How Will I Know a Client Is Ready?

Clients can respond to being HIV infected in many different ways. Some clients may want to discuss partner concerns and counselors may be tempted to monopolize on these situations. However, it is imperative that the OC's needs are addressed either before or simultaneously with the PCRS discussion.

Cue: *"What about my partner/spouse?"*

Response: *"We have services for your sex and needle-sharing partners and we can talk about their needs today, too. I'm concerned about what testing positive means to you and how that may affect your relationship with your partner/spouse?"*

Cue: *"I was expecting this [positive result]."*

Response: *"Even though you were expecting to test positive, I can imagine you may want some assistance from us. We have referrals for you and for your sex and needle-sharing partners."*

4. Ongoing Service

PCRS should be offered on a routine basis to all HIV positive clients. The OC should be made aware that receiving assistance in the referral of partners is optional and will be offered again. It is also critical that OCs understand that this intervention can play an important role in their own health as well as their partner's.

5. Identifying Appropriate Staff

It is strongly recommended that HIV program coordinators consider individual staff skills when determining who or which classification of staff will be assigned to PCRS elicitation on an ongoing basis. If a counselor is not comfortable with the concept of PCRS, then he/she should be expected only to introduce the topic, not elicit names.

In areas with low rates of new positives at C&T sites but high numbers in clinical services, the logical place to conduct PCRS would be EIP, HIV clinic, and HIV/AIDS case management programs. Areas with high incidence of new positives at C&T sites, outreach or other prevention operations may need to have a broader range of people trained to elicit names. Local areas with well-developed STD referral programs may want to negotiate an agreement with the STD Control Manager to rely upon DIS for elicitation as well as notification services.

VI.

WORKING WITH PARTNERS

The field worker should be prepared to handle whatever problems or distractions may arise during the notification process. Before a notification takes place, a confidential setting must be assured. Then, the sex or needle-sharing partner is informed of his/her possible exposure to HIV and supported in processing this information. Using a client-centered approach, the notification specialist answers and attends to the partner's needs. As the intervention proceeds, the notifier may take on the role of a prevention counselor. The notification specialist must be prepared to assist the partner in determining his/her next step.

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Program Standards for HIV PCRS Field Services

The following standards should be achieved by all DHS/OA-funded local health jurisdictions.

1. California State Law

California Health and Safety Code (HSC) Section 121015 protects physicians, surgeons, and local health officers from any civil and criminal liability that may result from their notification of sex and needle-sharing partners.⁴¹ State and county HIV partner notification specialists or disease intervention specialists (DIS) act as designees of the local health officer and, as such, are protected by HSC §121015 provisions. Local health jurisdictions must adhere to the provisions of HSC §121015.

Because of possible civil or criminal liabilities, DHS/OA strongly discourages any provider other than those protected by state law from conducting provider-only referrals.

If resources allow, local PCRS specialists or programs must accept requests for partner follow-up that originate from any provider who requests assistance.⁴² Should a local program be unable to provide field notification services, the program may contact the DHS/STD Control Branch, Area Field Office to request assistance.⁴³

2. Confidentiality

Strict confidentiality procedures that protect the identity of all OCs and named partners shall be maintained under all circumstances.

Confidential procedures to protect the names and identities of all persons served by HIV PCRS specialist or programs includes specific standards to be established for:

- ◆ Record-keeping
- ◆ Data reporting
- ◆ Verbal interactions between staff and management
- ◆ Transfer of information between health jurisdictions
- ◆ Responding to client and partner questions
- ◆ All clinical and field activities that involve maintaining or disclosing identifying client or partner information

3. Priority Action

Initial efforts to reach a named partner must be taken within 24 hours after the elicitation session.

The purpose of HIV PCRS is to interrupt the transmission of HIV and to improve partner access to HIV prevention counseling, testing, and related services. Any attempt to stop the cycle of HIV transmission must be implemented quickly in order

to increase the likelihood of successful contact and disease intervention. Once a partner is identified and locating information obtained, this information must be transferred to the PCRS field provider (or STD program if appropriate) and initiated for follow-up within 24 hours.

4. Evaluation of Notifier's Abilities

Evaluation of field worker activities must be included in the annual PCRS program assessment process. Evaluation should include a standardized assessment of locating skills, HIV exposure notification and counseling proficiency, and a client satisfaction survey of notified persons.

It is important to note the differences between the goals, and hence, the evaluation of HIV PCRS field interventions and STD contact tracing. Since many STDs are treatable, the goals are to locate exposed partners, offer screening and treatment if appropriate, and assess whether all possible source or spread candidates have been identified, located and treated.

Since HIV is not curable, the goal to identify potentially exposed partners for screening and preventative treatment is only valuable if incorporated into a larger context of quality service markers such as:

- Percentage of OCs to whom PCRS was offered;
- Counselor skill in making the offer or referral to PCRS;
- Counselor ability to accurately and consistently describe the various partner referral options with appropriate clients;
- Percentage of OCs who choose to have partners notified by PCRS staff or to notify partners themselves;
- Percentage of OCs and partners who are successfully referred to additional services, including C&T and other social/medical referrals; and,
- Qualitative analysis of client and partner satisfaction surveys.

As in other field operations, one quantifiable measure of a notification specialist's or PCRS program's success includes a review of partner disposition codes by individual workers. The "disposition" is a numerical coding system that indicates the outcome of a field intervention, such as: "partner located, tested and counseled," or "partner located – new positive." A monthly or bi-monthly summary of partner dispositions allows a program manager to look for worker trends and areas that may need improvement. It can also assist the individual field specialist to compare her/his personal "stats" to state or local averages.

Many HIV infected clients will choose to notify their own partners, therefore percentages of provider-only referrals may seem low when compared to STD rates. In addition, some partners, once notified of HIV exposure, may refuse to be tested. The differences between HIV and STD field service objectives makes it difficult for managers to determine the quality of HIV field services if they utilize typical markers for evaluating STD field services.

Another simple measure of how many clients (OCs and partners) maintain contact with the PCRS provider substantiates that the provider developed a good level of trust and rapport with the client and that the client will be likely to benefit from ongoing medical care and behavioral risk/harm reduction planning.

PCRS managers should regularly encourage HIV field staff for their efforts and remind them that, for some persons, providing the information and making the offer of PCRS can be a very appropriate outcome. The number of HIV positive and high-risk HIV negative clients referred to and retained in HIV care and prevention service systems as a direct result of PCRS interventions is a significant sign of PCRS success.

5. Accepting PCRS Requests from Outside Providers

The protocol described below is designed to meet Health and Safety Code requirements and to assure that partners are informed without unintended violent consequences. The following steps are strongly encouraged for the proper management of PCRS requests from physicians and surgeons who are not employees of the local health jurisdiction's HIV or STD clinic.

- Requests are immediately forwarded by the contacted health program to the designated PCRS specialist or program;
- The PCRS specialist or program determines that the patient's (OC) test result was confirmed by an FDA-approved supplemental test (e.g., IFA or Western Blot) or sets up an appointment to have the appropriate testing procedure performed. (When contacting the physician, the PCRS staff can ascertain the OC's testing procedures verbally without asking for the name of the OC.)
- The PCRS specialist or program ascertains whether the outside provider fulfilled the following California statutory requirements:⁴⁴
 - discussed the test result with the patient and offered education and counseling about transmission risks and how to avoid or reduce those risks;
 - obtained or attempted to obtain voluntary consent from the patient to notify partner(s); and,
 - informed the patient of provider's intent to notify or have partner(s) notified.

If statutory requirements **have been satisfied**, the PCRS specialist or program confirms with the provider that the patient has agreed to be contacted by the PCRS specialist or program.

- If the patient has agreed to be contacted by the PCRS specialist or program, the OC's name and locating information can be released and an elicitation session with the OC will be initiated by PCRS.
- If the patient has not agreed to be contacted by the PCRS specialist or program, but has already provided information and locating for a partner and has no concerns about D/PV, the PCRS specialist or program may initiate a FR for follow-up. No action can be taken if patient consent and D/PV assessment is not assured.
- If the patient has not agreed to be contacted by the PCRS specialist or program and was unable or unwilling to provide partner information to the physician, the PCRS process stops.

If statutory requirements have not been satisfied, the PCRS specialist or program should take no action until the provider can assure that the mandatory conditions have been met. If concern about domestic and other partner violence is ruled out, the local PCRS specialist or program staff will endeavor to work with the reporting provider to assure that the mandatory conditions can be met.

6. Partners Named under False Pretenses

Under no circumstances shall HIV PCRS specialists or programs accept unverifiable requests for partner follow-up from non-medical or unlicensed professionals.

PCRS specialists or programs do not act on PCRS notification requests made by the general public or anonymous callers. It is not uncommon for local health departments to receive anonymous telephone calls from citizens alleging knowledge of a HIV infected individual who is engaging in behaviors that could be spreading the virus to others. These callers often demand that the health department force the individual to stop engaging in high-risk behavior.

There may be some rare exceptions to this rule, to protect unwitting partners in extremely high-risk situations. These exceptions are quite rare and are considered individually on their own merit. In these instances, the local health officer must obtain verifiable documentation of a person's HIV positive status and willful intention to transmit HIV before any action can be initiated.

Recommendations for Field Service Programs

The following recommendations should be developed in local program procedures:

1. If Two or More Persons Who Live Together Are Named

In the event that two or more persons who live, work, or are institutionalized in the same location are named as partners to the same OC (or to more than one HIV infected client), their notifications should take place at separate times and, ideally, by different field staff. Risk of exposure should be considered when deciding which partner to contact first.

In small communities, neighborhoods, and closed-living environments, confidentiality is easily threatened, even under the most professionally and carefully protected situations. For this reason, more than one notification specialist should be available to offer PCRS notification and referral services to different partners who may know each other or have common sex or needle-sharing partners.

2. Services to Social Networks

DHS/OA and the DHS/STD Control Branch support outreach to specific localities, including bars, bathhouses, sex clubs and public sex environments as well as street corners where many persons may have sex with common partners. In these social networks, the most effective use of public health funds may be to focus on group education and outreach to encourage HIV counseling, testing and referral.

3. Referrals for Partners in Primary Relationships

Partners may need additional referrals related to their long-term primary relationships. Although this is not a service available through PCRS, the need for couples counseling was documented in a 1996 focus group survey conducted by the State of Colorado. The purpose of the survey was to determine the needs and concerns of HIV positive people who utilized HIV PCRS services for the notification of significant others. Several primary relationship-oriented needs were expressed that may be applicable to California PCRS recipients as well:

- respondents sought counselor support in disclosing serostatus to exposed partners;
- respondents requested assistance in maintaining relationships with primary partners;
- respondents wished to prevent abandonment by partners (as a result of PCRS) which could lead to future high risk behavior;
- respondents had a need for tools that would help to clarify the “health of relationships” to decide whether relationships should end or continue; and,
- respondents asked for counseling services for their partners, since partners often are the ones who hold the decision-making power to leave or stay.

One of the main barriers to PCRS can be the OC's fear of abandonment or other undesirable consequences. If PCRS specialists or programs can provide support and referrals for persons who are in primary relationships, the palatability of this critical intervention may be enhanced for current and ongoing relationships. Some innovative ideas that Colorado is pursuing in response to the focus group findings are:

- couples counseling services,
- voucher systems for counseling services,
- referral to community therapists, and
- social marketing strategies addressing PCRS.

4. More About Referral Development

It is essential that local programs maintain and update referral lists on a regular basis. The development of formal agreements between PCRS agencies and other service providers is strongly encouraged. Development of personal relationships between PCRS staff and local service providers may help ensure access by HIV positive clients and their partners. PCRS specialists or programs should identify culturally competent service providers for as many of the following services as possible:

Suggested Referral Directory Information

HIV Counseling and Testing	Crisis intervention/24 hour hotline
STD screening	TB screening
Support groups/other support	Rape crisis
Legal issues/restraining orders	Prenatal care
Harm reduction counseling	Drug/alcohol treatment and detox
Counseling/mental health	Benefits counseling
Domestic and other partner violence assistance	Housing assistance
Emergency shelter	Family planning services
Early care clinics	WIC/Maternal Child Health programs
Women's shelters	Select community-based organizations
Food banks	

Performance Standards for Field Staff

All field staff must follow established DHS/STD field procedures for locating, informing, counseling, and referring S/NSPs.

Field protocol for public health staff is clearly outlined in the “Performance Guidelines for Disease Intervention Specialists, 1988,” which can be obtained from the California Department of Health Services, Division of Communicable Disease Control, STD Control Branch at (510) 883-6600.

1. Offer of C&T

When partners are located and informed of their risk in the field, the notifier must be capable of providing immediate HIV C&T. Staff must have immediate access to all necessary C&T and PCRS forms, specimen collection materials and written health education and referral resources.

If local program protocol prohibits field specimen collection, PCRS field staff must provide HIV counseling as appropriate and offer direct assistance to refer a partner to a C&T facility that is convenient for the notified partner.

Because of the serious nature of PCRS notification, field workers who notify partners must be prepared to counsel them regarding their risk and be able to competently respond to their concerns. Most partners will be interested in HIV testing services unless they already know they have HIV. For this reason, testing should be made readily available. Local PCRS specialists or programs may be able to offer oral fluid specimen collection or urinalysis as an alternative to venipuncture, if the notification is conducted in the field. Both for convenience and for public health purposes, field staff should be trained and certified in HIV prevention counseling, universal precautions, and specimen collection procedures. Appropriate equipment must be provided to staff for collecting and transporting potentially hazardous specimens.

Field Worker Skills

An experienced field worker who has good locating information and a map can locate most partners. Field workers often rely upon common sense and are able to selectively inquire of third parties without breaching confidentiality. They adeptly check names on mailboxes and apartment buildings. They dress appropriately for the field, are quick to respond to questions about who they are, and carefully plan what to say, and not to say, to curious third parties. Specific training and ongoing support is required for these skills to be developed and enhanced.

For partners who wish to be tested elsewhere, a complete listing of local C&T sites and services, including anonymous testing, if available, must be provided. The notifier should be prepared to assist the partner in deciding test site selection by answering questions regarding hours of operation, scheduling requirements, and how to get there. Testing services should be made available within two working days and transportation needs must be assessed and resolved by field staff.

2. Awareness of Partner's Process

Employing good client-centered counseling skills will enable the notifier to stay focused on the partner's reaction to learning of their potential exposure and assist the partner in understanding the meaning of the information. Some partners may need immediate assistance, have many questions, or be very grateful for the notifier's efforts. Other clients may need to have time alone, wish to speak with a significant other or family member, or be angered by the intrusion and overtly agitated by the news. It is understandable that any number of partner responses may be possible and field staff must be prepared to respond appropriately.

It is also important to recognize that there is no immediate rush to have the partner tested or referred to treatment. Although partners may not have a choice in whether the field worker will attempt to locate them, they do have a right to refuse to speak with the notifier or to refuse testing. Field staff must be aware of the partner's need to process the information in any way necessary and attempt to make a personal "connection" at some level to create trust and facilitate a future meeting if possible.

4. Worker Safety

Since field referrals will be conducted in uncontrolled environments, that is, outside of a clinic or office, and often in unfamiliar surroundings, field staff must consider their own safety. Staff should always:

- know the exact address or location;
- carry a map or city guide;
- stay alert, pay attention;
- carry a cell telephone or regularly contact their office by pay telephone;
- work with a partner, if possible, when going into a problem area or after dark;
- ensure that a supervisor knows their planned stops.

Co-workers, outreach workers, and original clients are good sources of information about unknown neighborhoods and situations. They may be able to provide information about possible hazards, landmarks, and contacts. This may help keep the worker safe and expedite locating and notifying the partner.

Peer Training in Field Procedures

New or less experienced DIS should be paired in the field with veteran staff who can point out problem spots, demonstrate quick "on-your-feet" responses, and assist the newer worker in properly organizing field visits to make the best use of available time.

If a field worker encounters danger or threatening behavior from OCs, partners, or any other person while engaging in a PCRS intervention, the worker should remove his or herself from the situation as quickly as possible and report the incident immediately to the supervisor. A notification should be deferred indefinitely if the situation cannot be resolved.

Recommendations for Field Services Staff

The following recommendations should be regularly reviewed and practiced by field specialists and DIS conducting partner notification and referral services:

1. Conducting a Thorough Record Search

PCRS field workers must carefully review the partner identifying and locating information documented on the Partner Information Form or other notes. If there are any questions or inconsistencies, the field worker should contact the elicitor for clarification and additional detail.

A second step taken with a newly assigned FR is a complete in-house record search of appropriate and available confidential HIV and STD program records to determine if the partner is or has been a client. A timely and thorough record search may result in better or more current locating information or may provide sufficient information to properly disposition the FR without further follow up activity.

2. Contacting the Partner

Partners may be initially contacted in writing if no telephone is available or a face-to-face meeting is not possible. An envelope marked “personal and confidential” with an enclosed letter stating that the person is being contacted about an important health matter and requesting that they call or come into the clinic for more information may be left at the identified address.⁴⁵ The note, letter, envelope and business card should make no reference to HIV or STD.

Some field staff choose to initially contact partners in person. Because of the inability to assure the partner’s identify and provide adequate counseling, the field staff usually sets up an appointment to meet with the partner. The meeting usually involves a visit to the partner’s home, hang out, parking lot or agreed upon place. When negotiating with the partner where the meeting will occur, field staff must take into account the following considerations:

- ◆ Confidentiality and privacy,
- ◆ Environmental capability to collect a blood, urine or oral fluid specimen should partner wish to be tested,
- ◆ Availability of support for client and counselor if necessary,
- ◆ Worker safety issues.

When conducting face-to-face contact, staff must be cognizant of the partner’s potential feelings of shock and sense of violation of “personal space.” They must be extremely humble yet self-assured as they inform the partner of the reason for their visit.

3. Offering HIV Testing

HIV prevention counseling will likely lead to a discussion of HIV testing in the field if local protocol permits. Once completing appropriate phlebotomy and specimen

collection training, the notifier is prepared to collect a blood, urine, or oral fluid sample if the notified partner wishes to be tested. If the partner chooses to be tested elsewhere, the notifier should discuss different testing options, including anonymous services, if available, and facilitate an appointment with a test site or a private physician. For physician referrals, notifiers should attempt to obtain the partner's permission to call him/her and discuss how the referral to the physician went and if the partner understood the meaning of his/her test result. Notifiers may be able to obtain the partner's consent to consult with the physician about risk issues and test results.⁴⁶

NOTE: Partners have the right to refuse to be tested and are in no way required to provide their test results to PCRS program representatives. Written authorization for the release of HIV specific information must be obtained before a partner's test result can be released.

4. Referring Partners to Other Services

Beyond HIV-specific concerns, an exposed partner may have other referral needs to which a PCRS provider can respond. These might include other medical concerns, drug treatment, mental health, domestic and other partner violence, anger management, and perinatal and/or family planning services. HIV knowledgeable providers in each of these fields should be included on the written referral list provided to partners. Partners should also be strongly encouraged to be screened for STDs including a pap smear for women if one has not been administered within the past year. Providing information and referrals to STD clinics should be a routine notifier practice.

5. Maintaining Contact

Whenever a partner is notified, it will be important to maintain contact with that individual to the extent that he/she allows. In some cases, follow-up testing may be required to assure that the exposed partner is no longer in the "window period." Partners may have additional questions or concerns that they feel only the PCRS notifier can adequately address. Field workers must be prepared to provide business cards and work hours to facilitate a partner's future access to them.

VII.

HIV PCRS CHALLENGES

“HIV PCRS may be of limited value to persons engaged in very complex relationships, such as those involving anonymous partners or partners who may react violently if told of their exposure. However, for many persons affected by this disease, offering and delivering PCRS may be the only means we have to interrupt the spread of HIV to an individual or a community.”

- quote from a PCRS counselor in Northern California

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PCRS for Injection Drug Users (IDU) and Their Sex and Needle- or Other Injection Equipment Sharing Partners (S/NSP)

Sharing needles, cookers, water and cottons used for injection drug use (IDU) carries a significantly elevated risk for contraction/transmission of HIV. Offering PCRS to HIV positive IDUs and their sex and needle-sharing partners (S/NSP) is strongly encouraged. DHS/OA recognizes that some HIV prevention programs have less experience in working with IDUs and their partners and special training may be necessary to provide these program staff with effective skills and techniques for working with this challenging population. Furthermore, determining which PCRS strategy is most appropriate for IDUs (individual partner interventions or targeted community outreach) may present an even greater challenge.

Some state and local HIV prevention programs have already gained considerable experience in reaching and serving IDUs and their partners and report that such services are feasible and likely to be effective. Some HIV positive IDUs want to notify their S/NSPs and are willing to participate in the PCRS process (Levy and Fox, 1998). Anecdotal reports from California outreach programs have demonstrated that many IDUs are actively involved in PCRS and bring their partners into a C&T service (client-referral). Information provided by these IDUs can help HIV prevention program managers gain insight into the magnitude and kinds of service needs of this special at-risk population and how best to target and deliver such services.

One of the potential benefits of PCRS is to identify previously undiagnosed HIV positive persons and to assist them in accessing medical care at the earliest possible date. With IDU partners this may not be a useful rationale. In many cases the new treatments are not offered to active users. Given the strict dosage regimens and significant consequences of non-compliance to medical treatments (such as drug resistance), physicians may be reluctant to prescribe medication to individuals who may have difficulty maintaining medication adherence. Referrals to drug treatment programs and other social services can be a great help to active users, but stopping drug use may not be a high priority for them. Access to other social services may offer greater incentive than medical treatment or drug rehabilitation.

Working with Clients Who Refuse To Notify Partners

Each PCRS specialist or program is responsible for establishing its own priorities and strategies for working with HIV positive clients who do not give consent for PCRS. At a minimum, the PCRS provider must attempt to explore the client's resistance, assess for potential or perceived barriers to PCRS, and attempt to resolve identified barriers if possible. It is extremely important to attempt to reschedule an additional PCRS session if the client is willing and to offer the client written referrals to other needed services.

Each PCRS specialist or program must develop written policies for offering additional counseling services to HIV positive clients who do not wish to have their partners or

spouses informed. At minimum, written policy outlining specific steps that should be taken to attempt to gain client consent.

Federal law and California policies prevent criminal or civil penalties from being charged against persons who choose not to self-disclose or to request provider-referral assistance. Again, PCRS is based upon the voluntary participation of the original client. Programs should endeavor to “keep the door open” so that clients will be encouraged to work through their concerns with disclosure and have partners notified.

Notification of a Partner against the Consent of the Original Client

California Health and Safety Code Section 121015 permits physician and surgeons to notify a suspected sex or needle-sharing partner of their exposure to HIV without OC consent. Physicians and surgeons are protected from any criminal or civil liability for any potential damages incurred as a result of a notification they may initiate.

The following conditions which must be met *in advance* of a disclosure:

- 1) the initial HIV positive test result (ELISA) must be followed up by an FDA approved confirmatory test (IFA or Western blot);
- 2) the notification must be made only for the purpose of diagnosis, care and treatment of the person(s) notified or to interrupt the chain of transmission;
- 3) the exposed partner is “reasonably believed” to be the spouse, sexual partner, and/or needle-sharing partner;
- 4) before a non-consensual notification can be attempted, the physician must:
 - ✓ discuss the positive test result with the OC,
 - ✓ offer the appropriate education and psychological counseling,
 - ✓ attempt to obtain voluntary consent to notify from OC,
 - ✓ inform the OC of his/her intent to notify the third party(ies).

In addition to meeting all of the above conditions, the code requires that physicians refer all notified third parties for appropriate care, counseling and follow up. The law also permits physicians/surgeons to disclose partner information to a county health officer so that the health officer, not the physician, conducts the notification. (In most health jurisdictions, the health officer delegates this duty to DIS on staff with the STD control program and/or the HIV/AIDS program.)

If, for any reason, a local program should determine that notification of a potentially exposed partner will occur without OC consent, then the provisions of Health and Safety Code Section 121015 must be implemented in their entirety.

Willful Exposure

California law provides for the non-consensual notification of potentially-exposed persons under very specific circumstances. There is also provision in law that allows for the prosecution of HIV positive persons who willfully expose partners to HIV. State and local PCRS providers do not perceive either of these situations as being a component of the voluntary, confidential service system referred to as “HIV PCRS.” In order to carry out non-consensual notifications, PCRS specialists may be available, however, only as an adjunct of their primary role as client and partner advocates. PCRS providers are highly trained experts who can assure the appropriate counseling and referral of all involved persons. To retain the integrity of the PCRS intervention, DHS/OA strongly discourages local PCRS programs from initiating follow-up of known partners without the consent of the original client.

In a separate document, DHS/OA will be providing recommendations and guidance regarding clients who willfully expose their partners to HIV. “Intent to expose” is challenging to distinguish and verify. It must be well established before California law applies. DHS/OA plans to collaborate with CDC to convene meetings and public forums to further address the role of public health in assuring that all at-risk partners are offered potentially life-saving information, especially where it is reasonably suspected that a partner is unaware of his/her exposure.⁴⁷

Rescinding a Request for Provider-Only Referral

The OC may rescind his/her consent to have partners notified at any time during the PCRS process, however PCRS providers must attempt to contact a partner within 24 hours of the elicitation session. Unless there is a real concern about safety, once the PCRS field worker contacts a partner, the partner becomes the “client” of the PCRS specialist or program and notification and referral services will be carried out.

Participation in PCRS services is always voluntary and the client's right to change his/her mind must be respected. A conflict can arise, however, if the OC attempts to rescind the notification after the field worker has made initial contact with the named partner. In other words, if the PCRS field worker has scheduled an appointment to meet with a partner and the OC subsequently requests that the notification be interrupted, the notifier will be unable to suspend PCRS unless a threat of harm exists. Should the OC contact the PCRS specialist or program in time to interrupt the notification process, the PCRS specialist or program representative should attempt to maintain contact with the OC to help the client work through any concerns. Ongoing contact may ensure that future cooperation can occur.

VIII.

DATA COLLECTION AND REPORTING

CDC-funded PCRS providers must collect data that help answer key questions about how well the PCRS program is functioning, the extent and quality of services being provided, the degree to which clients and their partners accept and are satisfied with services, and how PCRS and other prevention services can be enhanced.

- CDC HIV PCRS Guidance, December 1998, Section 5.2, page 17

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Pilot Data Collection and Reporting Process

In order to standardize the reporting of HIV PCRS activities, a data reporting system is being piloted during FY 1999/2000 in five health jurisdictions. DHS/OA has developed data forms to document demographic, risk and sero-status for OCs and partners. Once feedback from the pilot reporting process is received, the reporting mechanism will be reconfigured as needed and distributed statewide to all health jurisdictions. Training in data collection will also be provided at that time.

Depending upon circumstances, opportunities may be available for local programs to participate in the pilot data collection and reporting process. Interested program coordinators should contact the HIV PCRS Program Lead at (916) 445-0554. Programs involved in the pilot data process agree to complete supplied forms accurately, disposition all partners according to specified instructions, strip forms of all client identifiers, and then mail data to the State DHS/OA marked "confidential" at a designated post office box.

The following standards and practices are being employed in the pilot jurisdictions and will apply to all health departments participating in PCRS activities when systems are in place:

Standards for HIV PCRS Reporting

1. Confidentiality

All PCRS programs must maintain PCRS related records in locked files with access limited to PCRS staff. Where non-PCRS staff have a legitimate need to know information related to PCRS counseling or field intervention activities, the appropriate records will be reviewed by PCRS staff and necessary information provided with the prior approval of the local PCRS specialist or program or other designated manager.

Paper flow systems must be secure and monitored regularly. PCRS providers must also be careful not to inadvertently disclose a client's or partner's HIV testing history, sero-status or exposure potential to any unauthorized person. Data reported shall be stripped of names and other identifying information for original clients (OC) and partners. Once all named partners have been dispositioned and all required information fully collected and reported to DHS/OA on DHS/OA forms, all written PCRS records for are to be destroyed by the local jurisdiction. Records containing unique identifiers that cannot be attributed to an individual's name or identity may be retained. Data is to be reported to DHS/OA within thirty (30) days of the end of the month in which the case was closed.

Accurate and consistent data collection is a critical component for evaluating the effectiveness of a PCRS specialist or program to enhance overall HIV prevention efforts. PCRS data enable providers to better focus prevention efforts on those persons at greatest risk. To do this, however, the collected data must include scientific and behavioral risk, HIV/AIDS prevalence, and demographics of affected

communities. With accurate and consistent data, the staff of health departments, community-based organizations, and local planning groups can establish an effective mix of HIV prevention strategies.

2. Disposition of Partners

Local health jurisdictions participating in the pilot PCRS data reporting process report the final disposition of each partner follow-up to DHS/OA. CDC has supplied standardized disposition codes for reporting data in all sexually transmitted disease and HIV related partner follow-up. Disposition codes “01 through L” are used to report dispositions without client identifiers to DHS/OA.⁴⁸

The disposition of partners represents the final outcome of the PCRS intervention process. Final dispositions are documented directly onto the partner’s Field Record (FR).⁴⁹ Since PCRS reporting to DHS/OA will not include client names or other identifiers, all available CDC dispositions (1 through L) can be used when reporting to DHS/OA, including those that indicate the partner’s testing history and current sero-status.

3. Reporting Dispositions between Health Jurisdictions

Whenever possible, California health jurisdictions are encouraged to accept requests from other jurisdictions and to get back to the originating agency regarding the final disposition of any requested follow-up. Disposition codes “08 – L” withhold the partner’s HIV serostatus yet indicate that follow-up was initiated and completed for the partner.

Any health jurisdiction can request follow-up of a named partner who may reside outside the jurisdiction within which the OC received PCRS services. This could include other counties/cities in California, other states, and other countries. The agency that conducts the PCRS elicitation session is referred to as the initiating agency. The agency to which requests for follow-up are made is referred to as the investigating agency. CDC has assigned a unique code or number to each state, country or territory. California has done the same with each local health jurisdiction. “Investigation” is the term used for “follow-up” by CDC and is designated as such on the CDC data forms.

There is much confusion regarding how jurisdictions can report the disposition of cases initiated to or from other jurisdictions. Since California is not an HIV reporting state, any communication of a disposition that indicates the notified partner’s HIV serostatus is in violation of State law.

Once all appropriate data is reported to DHS/OA, the investigating agency would report the disposition to the initiating agency by using codes 8 through L. These codes document that field follow-up was conducted, whether or not the partner was located, and that final resolution of the case was accomplished, without implying the HIV sero-status of the partner.

4. Using Two Dispositions

As stated, the investigating agency should report the final disposition back to the initiating agency withholding information regarding the partner's serostatus. However, the investigating agency should also use a second disposition for the same FR when reporting data to DHS/OA. Since the report to DHS/OA contains no identifying information, the FR should document the full outcome of the partner intervention, namely: sero-status, client ID number (if tested by the PCRS provider or tested at a DHS/OA-funded HIV test site and still available), and any other pertinent information. This information is documented directly onto the FR.

5. Communication of HIV PCRS Information

In California, there are eleven area Interstate Communication Control Registry (ICCR) desks that can accept and delegate follow-up requests between counties/jurisdictions within California.⁵⁰ A local PCRS program representative should contact the regional ICCR desk to request follow-up of a partner who currently resides in another health jurisdiction in California. The headquarters ICCR desk in Sacramento will accept and delegate follow-up requests between California and other states, territories and countries.

6. Minimum Standards for Accepting PCRS Requests from Other Health Jurisdictions

In order to accept requests for partner follow-up from another health jurisdiction, the initiating agency must provide identifying, locating and exposure information for each partner to be followed.

A. Identifying and Locating Information

The initiating jurisdiction should provide a minimum of four (4) pieces of identifying/locating information to the investigating agency. Examples of four viable pieces of locating information would include:

- ◆ Name (preferably first and last)
- ◆ Age, race, sex, description (counts as one)
- ◆ Address and/or telephone (counts as one)
- ◆ Additional telephone number, work location or known hangouts

Depending upon local resources and staff availability, the investigating agency may choose to accept requests with less than four pieces of identifying/locating information.

B. Required Exposure Data

In addition, exposure information including dates and type(s) of exposure must be provided by the initiating agency. For HIV PCRS purposes, types of exposure include oral, vaginal, anal intercourse and injection drug use. Document all types of exposure that apply.

Some local PCRS programs also require date and type(s) of HIV tests performed on the OC, as well as the name of the laboratory that conducted the testing procedure before accepting requests from outside jurisdictions. Generally speaking, additional detailed information will ensure the validity of the test result and possibly protect the investigating agency from liability which may occur as a result of inadequate laboratory testing procedures, such as not confirming the initial EIA positive result with a Western Blot or IFA.

7. PCRS Follow-up in Support of AIDS Surveillance

When local or state AIDS Surveillance and Case Registry Programs request PCRS assistance for a partner of a reported AIDS case, PCRS staff must attempt to conduct the follow-up. If the partner is located, counseled and tested, the PCRS specialist or program must confidentially report back the risk history and serostatus of the partner to the AIDS Registry. This practice will help ensure that the Registry can update or reclassify the related AIDS case before it is reported to the DHS/OA AIDS Registry according to the California Code of Regulations, Section 2500 et seq.

AIDS case surveillance is a critical component of all local health jurisdictions' HIV/AIDS programs. AIDS has been a reportable condition in California since 1983. The case report from a local physician or hospital to a local surveillance program includes risk history, pertinent medical history, and personal identifying information. The local surveillance program then transliterates the name into a code and reports the case with all demographic, risk and diagnostic information to the DHS/OA AIDS Registry. This protection of confidential AIDS surveillance data has never been violated in California. Its purpose is to maintain an accounting of the disease's impact on public health, need for medical and other care services, transmission risks, effectiveness of various medical treatments, and documentation of disease trends that may influence public policy.

Local AIDS surveillance programs do not document or report partner names who may have been identified and/or notified by PCRS to DHS/OA. If a surveillance program becomes involved with partner follow-up, it may be the result of a provider's reporting a case of AIDS and simultaneously requesting the follow-up of a known partner. Many surveillance staff are cross-trained in PCRS and can conduct partner referrals themselves. If the follow-up is to be conducted by another program staff such as STD or PCRS, the partner's name and all pertinent locating information are then turned over to the notification provider. Whenever possible, the notifier should attempt to meet with the AIDS patient to assure patient consent, assess for possible risk of domestic or other partner violence, and accuracy of the partner information.

PCRS specialists or programs should develop effective working relationships with local surveillance programs to assist them in carrying out statutory reporting requirements, assuring that partner follow-up is conducted by trained staff, and facilitating the comprehensive reporting of accurate PCRS data.

The Benefits of Data Collection and Reporting

Collecting and analyzing HIV PCRS data will allow DHS/OA to provide critical information to state and federal legislators. Data will also provide local programs to evaluate the effectiveness of their efforts. The following data elements will be taken from the system currently being piloted:

- Number of HIV positive or AIDS diagnosed clients offered PCRS;
- Number of HIV positive or AIDS diagnosed clients electing to participate in PCRS;
- Number of at-risk S/NSPs identified;
- Number of S/NSPs who were past or present marital partners (exposure occurred within 10 years of OC's initial HIV positive or AIDS diagnosis);
- Number of S/NSPs elicited, initiated, located and referred by PCRS staff;
- Number of S/NSPs notified by OCs;
- Number of S/NSPs notified by PCRS providers;
- Number of S/NSPs newly identified as HIV positive; and,
- Number of S/NSPs with previous HIV diagnoses.

HIV PCRS Disposition Codes ⁵¹

01 Previous Positive: *When located, partner claims to have received a positive test result in the past. It is not necessary to verify the test result; client self-report suffices.*

02 Previous Negative, New Positive: *Partner has past HIV negative testing history and is newly identified as HIV positive as a direct result of this PCRS intervention.*

03 Previous Negative, Still Negative: *Partner has past HIV negative testing history and re-tests negative as a direct result of this PCRS intervention.*

04 Previous Negative, Not Re-Tested: *Partner claims past HIV negative testing history and elects to defer a re-test at the time of this PCRS intervention. This could include partners who choose to be tested by their private physician or at an ATS, for example.*

05 Not Previously Tested, New Positive: *Partner has no past HIV testing history and is newly identified as HIV positive as a direct result of this PCRS intervention.*

06 Not Previously Tested, New Negative: *Partner has no past HIV testing history and tests HIV negative as a direct result of the PCRS intervention.*

07 Not Previously Tested, Not Tested Now: *Partner has no past HIV testing history and elects to defer testing at the time of this PCRS intervention. This could include partners who choose to be tested by their private physician or at an ATS, for example.*

08 Partner/Positive Test Patient Notified: *Partner was notified of potential exposure (no testing history or current testing election/result provided) OR “no-show” client notified of positive HIV status. This disposition merely verifies that the notification of the partner was successful, without reference to HIV serostatus OR that the HIV positive no show client was contacted and notified of his/her positive test result.*

09 Partner Notified, States Previously Counseled and Tested: *Partner was notified and indicated recent HIV testing. This would typically indicate that a partner has been HIV tested in the recent past and does not indicate partner’s serostatus.*

G Insufficient Information to Begin Investigation: *PCRS elicitor did not obtain adequate identifying/locating information to begin a follow-up of partner.*

H Unable to Locate: *An attempt was made and partner was not located. There are usually multiple attempts to locate a partner before this disposition is used.*

J Located, Refused Examination: *Partner was located but refused to be notified or tested. This would indicate that the partner was found, however, neither the HIV exposure information nor HIV counseling was provided. Example: partner slammed the door in the notifier’s face.*

K Out of Jurisdiction: *During the course of attempting to locate the partner, it was discovered that the partner had moved to another jurisdiction. This FR would be closed as a “K” and another FR would be initiated in the new jurisdiction to which the partner moved, if known.*

L Other: *Any outcome that is not covered in the above dispositions would fall under “L.” “Other” dispositions should be rare and must include a brief explanation.*

IX.

DOMESTIC AND OTHER PARTNER VIOLENCE

A person's HIV status can "trigger" domestic violence in relationships or exacerbate already existing abuse within a relationship. It is important to understand that HIV/AIDS does not cause a partner to be abusive, but rather that an abusive partner can use his or her partner's HIV [positive] status as a weapon of abuse ... The abusive partner may withhold basics from the victim, e.g., withholding medications, refusing to feed, leaving the victim alone when the victim needs constant care.

- "HIV and Domestic Violence in Sero-Discordant Couples," T.A. Maroney and A. W. Brown,
- New York City Gay and Lesbian Anti Violence Project

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Description

Domestic and other partner violence (D/PV) has been described as a pattern of assaultive behaviors including physical, sexual and psychological attacks as well as economic coercion that adults or adolescents use against their intimate partners.⁵² D/PV is an emerging term that adequately reflects the broad range of situations in which violence between partners can occur. Someone who is, or was, involved in an intimate relationship with a potential victim can perpetrate D/PV. Victims are most often female, however males can also be victims of abuse. D/PV behavior can be found in all types of relationships – heterosexual, gay, lesbian, committed and non-committed. It occurs in all communities, regardless of race, class, ethnicity, ability/disability, age, sexual orientation, religion, education, politics, or lifestyle. While there is a full range of behaviors that may be considered as violent, this policy specifically addresses physical abuse as opposed to verbal or emotional abuse.

Standards for D/PV Assessment, Documentation and Referral

1. Assessment

If a PCRS notification would or could put a HIV positive person or his/her partner(s) at risk of violence, the safety of the affected person(s) must be reasonably secured before the PCRS intervention can take place.⁵³ Further, if the original client (OC) requests that notification not be conducted because of a partner's possible violent reaction, PCRS activities must be deferred indefinitely or until the OC gives verbal or written consent. The PCRS provider must adequately document the threat of domestic and other partner violence (D/PV) in the OC's medical chart or other appropriate encounter form.

Whenever D/PV is identified as a client concern, PCRS counselors must offer an immediate referral to a specialist, licensed counseling service, D/PV provider, or other appropriate agency for in-depth counseling and other related services.

During the partner elicitation process, PCRS elicitors must inquire, on a partner-by-partner basis, whether violence directed at a partner, the OC, or significant others (children) could result from a notification attempt. Whenever it is determined that a serious risk of violence exists, field notification should be deferred or discontinued altogether until the situation is adequately resolved. If a situation cannot be resolved, the local PCRS specialist or coordinator or other appropriate supervisor must review the case before it is assigned for follow-up.

2. Documentation

HIV PCRS counselors must screen for D/PV risk during PCRS elicitation sessions and document findings in the medical record, Original Client Information Form and all relevant Partner Information Forms. If HIV counseling and testing services are provided as part of the PCRS intervention, D/PV information should be recorded in the “counselor notes” section of the HIV Counseling Information Form. Counselors should further describe whether the client is a victim or perpetrator.

Documentation is encouraged so that the client will be appropriately referred and case-managed. There is also value to documenting D/PV as it relates to the offer and acceptance of HIV PCRS. DHS/OA OC and Partner Information Forms include fields for documenting D/PV. California State law requires some licensed health care professionals to report injuries due to D/PV. HIV test counselors are not mandated reporters, however clear documentation is important to PCRS considerations. The following brief notations may be helpful for documentation:

D/PV + domestic and other partner violence identified

D/PV ? domestic and other partner violence suspected (provide some explanation)

D/PV - risk of domestic and other partner violence is low or non-existent

For non-DHS/OA funded providers who do not report HIV C&T or PCRS data, documentation of D/PV history should be recorded within the patient's chart or other appropriate record. Many providers choose to use the client's own words when documenting an abusive event, however, a simple notation which includes a descriptive sentence or two is also practical.

3. Referral

HIV PCRS counselors must offer to refer identified victims and abusers to appropriate D/PV programs or providers. This would include resources for men-who-have-sex-with-men and women-who-have-sex-with-women.

As violent patterns are identified, PCRS providers should begin a discussion of what, if anything, the client wants to do regarding the situation. If a client is ready to take action, it is important that counselors or providers fully assess what resources the client has, such as: health insurance, financial resources, child-care options and transportation. Further, any special needs the client may have must also be addressed (e.g., safety, bilingual services, youth specific services, gay/lesbian community services).

4. Development of Local D/PV Resource Listings

PCRS providers must develop written resource listings for D/PV specific counseling and referral services that are regularly updated.

Shelters, individual counseling, batterer intervention groups (anger management), and other related D/PV support services can be identified typically through the local district attorney's County Victim Witness Programs. Some counties also have established a Domestic Violence Coordinating Council that coordinates law enforcement and criminal justice responses. The Coordinating Council may also provide written resource listings. In addition, the DHS Family and Domestic Violence Prevention Program has developed a Family Violence Reference Directory on their website. The directory includes a county by county listing of specific D/PV referral services and is located at:

www.dhs.ca.gov/epic/html/dv_directory.htm

A national DV hotline is also regularly updated: **(800) 749-SAFE**.

Programmatic Recommendations

1. Local Program Responsibilities

All PCRS specialists or programs should implement the following protocol:

- ◆ Develop site specific D/PV policy and procedures, including client and staff safety precautions.
- ◆ Train all staff in how to implement the procedures.
- ◆ Develop accurate resource listings for clients who are ready for assistance in D/PV.
- ◆ Establish verbal or written agreements with at least two D/PV specialty providers for immediate referral of clients.
- ◆ Identify trained, preferably licensed staff on-site who can intervene with clients if needed.

2. Training in D/PV Assessment

D/PV is described in both HIV PCRS Counselor Training courses provided by the STD/HIV Prevention Training Center (PTC). Participants are given the opportunity to role-play situations involving D/PV and to work through some discomfort with the topic itself. Attendance and successful completion of this course is required of all PCRS elicitors who are or will be conducting elicitation services in local health jurisdictions. Training is also available to private and other public health professionals.

3. D/PV and Client-Referral of Partners

HIV positive persons should be discouraged from revealing their HIV status to any partner who may threaten their physical safety.

For HIV PCRS sessions, the need for PCRS providers to assess for D/PV potential is even more important when HIV positive clients choose to notify partners themselves (client-referral). It is not uncommon for victims of abuse to feel responsible for their abuser's welfare. A victim's need to protect his/her partner may be a stronger motivation than personal safety. Counselors should emphasize the possible adverse consequences of client-referral and assist the OC in developing an alternative plan to reduce the risk of continued exposure through ongoing sex or needle-sharing. Referring the OC to D/PV support programs may help to resolve other issues that can promote the notification of the partner if necessary.

4. D/PV and HIV Prevention

Introducing condom use or other safer sex practices can be extremely challenging in abusive relationships. Abusers may become angry if the victim were to suggest such a behavior change. Counselors must listen carefully to clients when exploring risk and contextual factors and make every effort to provide reasonable, workable solutions around risk/harm reduction methods and refer clients who indicate a desire for support.

Messages for PCRS Counselors

1. D/PV Training

Although D/PV assessment and referral skills are taught in the HIV PCRS training courses and other DHS/OA HIV Counselor trainings,⁵⁴ it will be important for program managers to encourage staff to seek additional training in D/PV assessment and referral skills. Training is available through the STD/HIV Prevention Training Center in Berkeley and the Family Violence Prevention Fund in San Francisco. Please also refer to the Appendix for "D/PV Assessment Guidelines" in HIV counseling and tips for "Recognizing the Pattern of Abuse" in clients.

2. Limited Role of PCRS Counselors

HIV PCRS counselors should recognize that patterns of violent behavior and corresponding survival behavior patterns are extremely complex. Therefore, the role of the PCRS counselor is simply to assess and make appropriate referrals for clients who are ready to accept them.

3. Be Prepared

Trained PCRS counselors must recognize that effective, non-judgmental, client-centered counseling may expose a client's abusive history. He or she may resent the disclosure and not be amenable to an intervention. PCRS specialists or programs must assure that PCRS counselors are prepared to diffuse undesirable client reactions or that staff support is available should a counselor need assistance.

4. Selecting the Most Appropriate Referral

Some research holds that traditional couples counseling and rehabilitation programs (substance abuse, mental health) may not be effective in working with D/PV issues. Counselors should discuss a variety of referral options with clients who are ready to take action. If counselors are unfamiliar with a facility, they should contact it to ascertain whether it is able to provide the necessary support and protection.

5. Field Worker Safety

Sometimes violence may be directed toward a field specialist (DIS) who may conduct a notification in the abuser's home. If the local program director and medical team determines that a notification must take place, even though it may present a risk to the DIS, additional safety measures must be considered. These measures could include using two male DIS, providing DIS with cell phones, or scheduling the encounter at the health department or a public place.

6. California Codes

Penal Code §261.5, §288(a,c)	Statutory Rape
Penal Code §11160-11163.6	Mandated Reporting of D/PV Injuries
Penal Code §11165.5	Child Abuse Reporting
Welfare and Institutions Code §15632	Dependent Adult Abuse Reporting

X.

QUALITY ASSURANCE

Quality assurance for PCRS programs entails ensuring that appropriate and standardized methods are used for:

***counseling HIV-infected clients
developing a PCRS plan with infected clients;
prioritizing which partners are to be reached;
locating and informing partners;
offering C&T and other needed referrals to all notified partners; and
collecting, analyzing and storing PCRS data.***

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Local Program Evaluation

HIV PCRS providers must provide elicitation and notification staff with opportunities to attend and successfully complete all required DHS/OA HIV counselor training courses. At minimum, on an annual basis, programs must assess the competence and effectiveness of the local PCRS intervention through direct observation of elicitation and notification sessions, system walk-throughs, and data reporting and record keeping procedures. Staff performance evaluations and standards should be provided in written form. Evaluation tools must be universally implemented to assure standardization and consistency when conducting staff reviews.

The following program areas or activities should be conducted or reviewed:

- 1) culturally competent counseling and education services,
- 2) notification services to partners,
- 3) confidentiality procedures for records maintenance,
- 4) accuracy of data collection and timeliness of reporting to DHS/OA,
- 5) inter-jurisdictional sharing of information,
- 6) required staff training compliance,
- 7) adequacy of referral linkages, and
- 8) client/partner satisfaction surveys.

Each program should be able to quantify its efforts at eliciting and locating S/NSPs. Programs must be able to provide and verify partner testing rates and sero-incidence.

PCRS Counselor Evaluation

The manner in which HIV-affected communities perceive PCRS determines in large part how successful the program will be. Therefore, program managers and supervisors should ensure that all elicitors and field staff are trained and adequately skilled in the following areas:

- ◆ delivery of client-centered counseling,
- ◆ relating to clients from diverse ethnic and cultural backgrounds,
- ◆ describing the various partner referral options,
- ◆ gathering and recording OC and partner information,
- ◆ developing personalized and appropriate partner referral plans,
- ◆ “coaching” clients choosing client-referral,
- ◆ completing PCRS forms,
- ◆ conducting field notifications (if applicable),
- ◆ identifying OC and partner needs and facilitating appropriate referrals, and
- ◆ protecting client confidentiality.

Required Training

The following courses are required of HIV PCRS elicitation staff:

- ◆ DHS/OA HIV Counselor Training Basic I (if working in a C&T site),
- ◆ DHS/OA HIV Counselor Training Basic II (if working in a C&T site),
- ◆ DHS/OA HIV PCRS Training (three day course)

The following courses are required of HIV PCRS notification staff:

- ◆ DHS/OA HIV Counselor Training Basic I,
- ◆ DHS/OA HIV Counselor Training Basic II,
- ◆ DHS/OA PCRS Workshop for DIS (one day course),
- ◆ CDC Introduction to Sexually Transmitted Disease Interventions (ISTDI) or equivalent.

All courses are available through the DHS/OA HIV Counselor Training Program (Basic I and II) or the STD/HIV Prevention Training Center (both PCRS courses and ISTDI).

Recommendations

1. Other Training

Other training and support that will further enhance counselor skills and abilities to serve clients effectively are:

- ◆ Understanding cultural competence;
- ◆ Enhancing client-centered counseling skills;
- ◆ STD symptomology and treatment protocol;
- ◆ HCV and TB symptomology and treatment protocol;
- ◆ Attending updates that address HIV infection, transmission, and treatment;
- ◆ Studying local, state, and federal laws regarding HIV confidentiality and disclosure as well as other relevant statutes addressing public health care;
- ◆ Having direct experience with or knowledge of local substance abuse treatment services, mental health providers, and other health care services.

Health jurisdictions that provide PCRS should keep counselors current on updated treatment information and research findings and provide periodic retraining. Counselors should be appropriately supervised and given oral feedback about their performance on a regular basis.

In addition to formal training, a newly trained PCRS provider should complete an internship by being teamed with a more experienced provider for a pre-defined period of time before conducting PCRS alone. Routine peer review of selected cases is another way to enhance PCRS counselor performance.

2. Bi-lingual/Bi-cultural Services

PCRS specialists or programs must make every effort to select and train HIV prevention staff from a variety of ethnic backgrounds and having multi-lingual capacity, based upon the program's client demographic base.

3. Networking Capacity

Networking with other public health programs (EIP, STD, HTPP, CBO, and LIG) is critical to PCRS acceptance and success. Local PCRS specialists or programs should offer to conduct in-services for other public health personnel who may be interested in PCRS. Local programs can consider facilitating a community forum to establish links with and receive input from local HIV-affected persons. It is strongly recommended that local PCRS specialists or programs request time on the agenda at local implementation group (LIG) meetings to become established with and accountable to the HIV community planning process.

XI.

DEFINITION OF TERMS

AND

ACRONYMS

The following terms and acronyms may be unfamiliar to some readers because they describe the programs, processes and activities used to reach and serve sex and needle-sharing partners of HIV positive persons. This reference should be of assistance when developing a local response to serve HIV positive persons and their partners.

First and foremost, partner counseling and referral services is new terminology that was coined in December 1997, in San Francisco, California, during a meeting of the State [PCRS] Guidelines Committee. This group of HIV and STD providers from San Francisco, Los Angeles, Atlanta (CDC) and Sacramento (OA) agreed that “partner notification” and “contact tracing” were outdated terms that were no longer useful. The terms not only carry a history of suspicion and misunderstanding among our HIV affected community, but also they are incapable of reflecting the range of public health services we planned to incorporate into a comprehensive, user-friendly, voluntary partner intervention endeavor. After a great deal of discussion, including one that addressed the length of the new acronym, PCRS, it was decided that the country would become familiar with the term in time and that a term of shorter length would not acknowledge the difference between the client-centered approach of today and the “tracking” approach of the past.

AIDS Surveillance Program- Federally and state funded local and state programs that identify and report in a confidential manner all cases of AIDS diagnosed in any local jurisdiction. These cases are then reported to the state's AIDS Case Registry, then to the CDC.

At-Risk Partner- Any sex or needle-sharing partner of a HIV infected person who may have been exposed during the time the original client was infected.

ATS- Alternative Test Site. State funded and mandated HIV testing facilities that provide free and anonymous HIV C&T. Clients are identified by a unique number. Verbal consent-to-test is obtained.

Attending Skill- An active listening skill that conveys interest in the client's needs and pays attention to the client's rationales.

Biological Motivators- Biological or health related consequences which may motivate behavior change and maintenance. Some examples are: possible infertility from untreated STDs, re-infection with treatment resistant strains of HIV, and difficulty in treating HIV and STDs if co-infected.

CBO- Community Based Organization. Generally, a not-for-profit, tax-exempt organization, directed by and serving a specific community or communities.

CDC- Centers for Disease Control and Prevention. A federal agency that administers federal funding to a variety of local and community disease control and prevention programs.

CIF- Counseling Information Form, used at DHS/OA-funded HIV C&T sites to collect data and aid the counselor in conducting risk assessment and result disclosure sessions.

Client-Centered Counseling- An interactive counseling approach that focuses on the unique needs, social and contextual factors, and specific issues raised by a client.

Client-Referral- As distinct from Provider-Referral, the HIV positive client assumes the responsibility for notifying a partner of the possible exposure to HIV and the need to seek HIV testing.

CMP- AIDS Case Management Program. State and federally funded program for AIDS diagnosed individuals. Provides nurse and social work case management, psychosocial, medical, attendant care, and a number of other services.

Contract Referral- A notification whereby, if the OC is unable to inform a partner by an agreed upon time frame, the PCRS provider has the permission and information necessary to do so.

CTS- Confidential Test Site. Any HIV testing venue that provides HIV antibody testing in when the client's name is known. Signed consent to test is required of all DHS/OA-funded CTS facilities.

C&T- HIV Counseling and Testing. Generally refers to DHS/OA-funded HIV testing programs. Clients testing in these programs are provided HIV prevention counseling, risk assessment, risk reduction planning, and referrals to other services as needed.

Cultural Competency- or cultural proficiency. A group's design for living which could include: the ways in which people understand the world and their place in it; beliefs as to what is right and wrong and meaningful in life; understandings of how one should act, think and feel; and expectations as to how others will behave.

CDCC- Division of Communicable Disease Control. A division of the California State Department of Health Services that includes the Sexually Transmitted Disease Control Branch.

Detuned Assay- A less sensitive version of the current ELISA test for HIV antibodies used to determine if a person was exposed/infected within the past 6 months. This information can be useful for determining treatment options and more accurately pinpointing the necessary interview period to determine the priority in which partners are to be notified. Not yet approved by the Federal Drug Administration for widespread screening of HIV positive specimens, some state and local health departments have received federal funds to conduct trials and determine efficacy.

DHS- State of California Department of Health Services. The Office of AIDS is a Division of DHS.

Disclosure Session- The HIV post-test counseling session in which the result is disclosed; the meaning of the result is discussed; the risk reduction plan is reviewed; and necessary referrals are made.

Disposition- A code used to indicate the outcome of a partner follow-up.

Domestic and Other Partner Violence- A pattern of assaultive behaviors, including physical, sexual, and psychological attacks as well as economic coercion that adults or adolescents use against their intimate partners.

Dual-Referral- A notification approach whereby the HIV positive client and the PCRS provider inform the partner together.

EIP- Early Intervention Program. A local, state or federally funded program for HIV infected individuals that provides on-going social work case management, psycho-social and medical services. Often the first service accessed by people newly aware of their HIV positive status.

Elicitation- The process of gathering sufficient identifying, locating and exposure information on a possibly exposed partner in order that a successful field notification can take place.

Elicitor- A person from a HIV or STD program who works with an Original Client to offer PCRS, address client concerns, gather partner information and initiate partner follow-up.

Exposed partners- Sex and or needle-sharing partners who potentially may have been exposed to HIV by an HIV positive person.

Exposure Type- Refers to the way in which a partner may have been exposed such as, sharing needles or drug injection paraphernalia or anal receptive sex. Must be specific to the type of

exposure (insertive, receptive, IDU) and the location of sexual exposure (oral, anal, vaginal). Should document whether exposure was protected or unprotected. Distinguished from “Type of Partner” which refers only to sex, needle-sharing or both.

FDA- Food and Drug Administration. The federal regulatory agency that approves drugs and diagnostic technology.

Field Follow-Up- Locating and informing a partner of possible exposure to HIV or other communicable disease. Used synonymously with “field notification.”

Field Notification- The process by which named partners are located and informed of possible exposure, offered HIV prevention counseling and risk reduction planning, and offered HIV testing directly or by referral.

Field Record- (FR) A CDC form designed to assist case management efforts. The form is used to document attempts to locate and refer sex and needle-sharing partners of STD/HIV infected clients.

Good Faith Effort- As defined by CDC, any attempt to locate a partner (specifically a past or present marital partner), inform the partner of possible exposure to HIV, offer HIV testing, counseling and risk reduction planning, and documentation of the outcome.

HCW- Health care worker. Can include licensed medical professionals, licensed therapists involved in health care work, and para-professional HIV counselors and PCRS providers.

Health and Safety Code- California legislative statutes that are numbered and grouped into similar categories are called codes. For example, many statutes dealing with health issues are grouped together in the Health and Safety Code and the body of statutes dealing with crimes and their punishment are found in the Penal Code. All of the California statutes collectively form the California Codes. The terms “code” and “statute” are often used interchangeably.

Health Officer (HO)- The county, city, or district health official with responsibility for the overall public health of that jurisdiction..

Highly Infectious Period- Refers to a time period when the level of HIV virus in a persons blood (viral load) is extremely high, therefore increasing the risk to exposed partners. This is usually in the early stages of infection before the body is able to produce antibodies against the virus. The viral load is usually reduced to low levels by the initial response of the immune system. As the virus defeats the immune system the viral load may go up again, increasing the risk to partners again.

HIV 2- A subtype of the HIV virus transmitted largely through heterosexual contact. Indigenous to West Africa, specifically along the Ivory Coast.

HIV Counselor Training Certification- HIV risk assessment and disclosure counselors are required to successfully complete the Basic I and Basic II counselor training courses and be re-certified annually to be a HIV test counselor in DHS/OA-funded test sites.

HTPP- HIV Transmission Prevention Project. In California, the HTPP is based on CDC guidance for HIV Prevention Case Management, 1998. DHS/OA is currently funding a HTPP demonstration project to provide enhanced risk reduction counseling, planning and case

management to HIV positive individuals at high risk of transmitting HIV and to HIV negative individuals at high risk for contracting HIV.

HIV Prevention Counseling- See “Risk Reduction Counseling.”

ICCR- Interstate Communications Control Registry. The registry that confidentially manages incoming and outgoing requests for follow-up of partners in other jurisdictions.

IDU- Injection Drug User.

Individual Service Plan- Developed in a case management program for each individual client. It is the “medical record” counterpart that documents service provision.

Informed Consent- Consent for the administration of medical care or laboratory screening/testing. Clients must be fully informed of the risks or benefits of PCRS before partner elicitation can begin. Consent may be verbal or written.

Interview Period- The period of time from which partners will be elicited for PCRS services. Generally this will be one year, unless specific information indicates differently, for instance a history of recent HIV negative test or self reported belief of when the original client became infected. The Interview Period for marital spouses is 10 years.

Interview Record (IR)- A CDC form designed for use by state and local STD disease intervention specialists (DIS) to document interviews of individuals who have a reportable communicable disease. This form may be used by the local HIV PCRS specialist or program but is not necessary because of the Original Client Information Form now available to local jurisdictions.

ISTDI- Introduction to Sexually Transmitted Disease Intervention, a 10-day training required for STD program staff who conduct partner management interviews and field notification of partners. Primarily focuses on syphilis investigations, however includes training in field interventions.

LHD, LHJ- Local Health Department, Local Health Jurisdiction.

Local Planning Group/Local Implementation Group- A body of members from LHJ, CBO, HIV service providers, advocacy organizations, academic institutions, and HIV affected persons who develop local community HIV prevention plans which are then implemented as programs and interventions.

Marital Spouses- For the purposes of this document, marital spouse is a legally married partner, either past or present.

MCWP- Medical Waiver Program. Services for late stage AIDS diagnosed individuals. Provides nurse case management and medical services.

Names-Based HIV Reporting- Many states require local programs to report HIV cases to the state by name of the HIV positive person. California is not a name reporting state. Currently California does not report HIV infections, only AIDS cases.

NIR- No Identifiable Risk. A designation assigned to an AIDS case when there is no risk identified on the report to the local health jurisdiction.

Non-reportable condition- Medical conditions that are not required to be reported to the local health department.

No Show Client- A HIV test client who does not return for the result disclosure session.

Notifier- For the purposes of the California PCRS program, typically STD program staff with responsibility for locating and notifying identified partners of their possible exposure to HIV.

NSP- Needle-sharing Partner. Any person with whom drug-injecting equipment is shared. This includes needles, syringes, cottons, and cookers.

OOJ- Out of jurisdiction. Used for case dispositions. Refers to the location of a partner or original client who resides in another health jurisdiction in California or another state or country.

Oral Fluid Sample- A sample of cells and fluids that is collected with an OraSure® oral fluid collection device. An absorbent swab treated with chemical salts pulls cellular fluid from the tissues in the mouth that can then be tested for HIV antibodies.

Original Client (OC)- Any HIV positive client offered PCRS services by staff of any program from C&T to case management, or private medical services. Also referred to as “original patient” or “index case.”

Original Client Information Form- A newly designed DHS/OA reporting form that enables local PCRS programs to report data on specific HIV positive persons using a coded system.

PCRS Counselor- PCRS elicitor or notifier. This person can be involved in PCRS on a full-time basis or as an HIV C&T counselor or STD worker, for instance.

PCRS Provider- Can refer to an individual who or a local health department program that offers PCRS assistance to clients and medical communities. PCRS providers can conduct any number of activities including: introducing the topic of partners to OCs, developing a partner referral plan, “coaching” an OC in how to inform a partner (client-referral), eliciting partner names/locating information for follow-up, and the actual notification of a partner either in the field or other appropriate location. The PCRS provider can be an HIV C&T counselor, an EIP or CMP social worker, a licensed physician, a field specialist, STD counselor, or any other number of professions that serve HIV positive persons.

PMD- Private medical doctor. Refers to a physician who is not part of the public health system.

Partner Information Form- A newly designed DHS/OA reporting form that enables local PCRS specialists or programs to report partner data by a unique coded system.

Partner Management Training- There are five trainings offered by the CDC through the STD/HIV Prevention Training Centers which are focused on the identification, location and referral of partners potentially exposed to specific communicable diseases, such as HIV, gonorrhea, and TB.

Partner Notification- Refers to the component of PCRS performed by the field staff who locate and inform named partners of their possible exposure to HIV.

Positive No Show- When a HIV test client whose result is positive does not return for a positive HIV result. In confidential settings an attempt will be made to locate these persons and encourage their return for the results.

Potentially Exposed Partner- Sex and or needle-sharing partners who may have been exposed to HIV by an HIV positive person..

Prevention Case Management- In-depth, multi-session HIV risk reduction counseling and case management provided to high risk HIV positive and high risk HIV negative clients to assist them in initiating or sustaining practices that reduce or prevent HIV transmission and acquisition.

Provider-only Referral- As distinct from Client Referral, field program staff assume full responsibility for locating, notifying, and referring sex and needle-sharing partners regarding their possible exposure to HIV.

Provider-assisted Referral- Provider-assisted Referrals include Provider-Only, Dual- and Contract-Referral methods.

STD/HIV PTC- California STD/HIV Prevention Training Center. A unit within the DCDC, STD Control Branch. One of ten national training centers funded by the CDC.

Referral- In HIV PCRS, “referral” can be used in two ways, which are not mutually exclusive, however, may need some explanation. 1) The traditional meaning of referral indicates a source of help or information to which a client is directed, such as a referral to a STD program or family planning provider for additional services. PCRS providers should have thorough, accurate, and frequently updated referral lists to meet any anticipated client need. 2) Another use of “referral” in PCRS designates the type of partner referral process that has been chosen, namely: client-, dual-, provider- or contract-referral.

Referral Plan- A plan developed by the PCRS provider and OC that outlines how each partner will be notified of his or her possible exposure to HIV. This plan may include all referral options: client-, provider-only, dual- or contract-referral.

Reportable Condition- Any medical condition that must be reported to the local health department, state and CDC pursuant to California Administrative Code Section 2500 *et seq.* These usually include infectious diseases such as AIDS and many STD’s, foodborne illnesses, malaria, tetanus, etc. It also includes any medical condition that is unusual in its occurrence. In California, HIV is not a reportable condition.

Risk Assessment Session- The HIV pre-test counseling session which is focused on assessing the testing client’s risk, developing a risk reduction plan, and scheduling a return visit to the site if the client chooses to test.

Risk-Reduction Counseling- The process of addressing the reported risk-taking behaviors in a client-centered manner. The counselor assists the client in developing a workable risk-reduction plan that is realistic, obtainable, and specific to the identified risks.

Risk Reduction Plan- An individualized plan developed by the counselor and the client to identify and address specific behavioral risks and set realistic goals for behavior change.

RWCA Title I, II, III- Ryan White Care Act. Federal funding act to fund state and local programs to provide services to HIV infected persons and their families. Title I is funding to high prevalence areas, i.e., San Francisco, Los Angeles, San Diego. Title II is funneled through the states to local consortiums to distribute funds on a local level. Title III provides funding to fill in gaps of service for direct medical care.

S/NSP- Acronym that refers to a sex and/or needle-sharing partner.

Self-Referral- Used synonymously with Client-referral. This is not necessarily the correct application, however, it is commonly used to designate client-referral.

Technical Assistance (TA)- Programmatic support provided at a local level by DHS/OA and STD/HIV PTC staff. Includes counselor evaluation, program review and situation-specific problem solving.

Unique Identifier- An unduplicated number or code used to track an individual without the use of their name or other identifying information. An additional effort to maintain client confidentiality.

Viral Genotyping- The genome, or individual characteristics, of a viron can be ascertained via genetic testing. This testing can be helpful in developing treatment plans to avoid increasing treatment resistance by various strains of the HIV virus.

Willful Exposure- A situation where a HIV infected person deliberately exposes another person through unprotected sex or needle sharing. There can be severe legal ramifications for anyone proven to have willfully exposed another person.

Worker Safety- Primarily refers to safety of program staff in the performance of job responsibilities related to the field.

XII.

FEDERAL PRINCIPLES FOR PROVIDING PCRS

The principles listed on the following pages constitute the basis for PCRS and are applied to issues discussed throughout [the CDC HIV PCRS Guidance]. Principles 1-11 apply to partner counseling and referral services associated with partner services for all sexually transmitted diseases, including HIV. Principles 12-13 apply to partner counseling and referral services associated with HIV in particular.

-CDC HIV PCRS Guidance, December 1998, Preface

CDC PCRS Principles

The following principles provided by the Centers for Disease Control and Prevention (CDC) in December 1998 have been wholly incorporated in California's PCRS Standards and Recommendations:

1. **Voluntary.** PCRS is voluntary on the part of the infected person and his or her [sex and needle-sharing] partners.
2. **Confidential.** Every part of PCRS is confidential.
3. **Science-Based.** PCRS activities are science-based and require knowledge, skill, and training.
4. **Culturally Appropriate.** PCRS is to be delivered in a nonjudgmental, culturally appropriate, and sensitive manner.
5. **A Component of a Comprehensive Prevention System.** PCRS is one of a number of public health strategies to control and prevent the spread of HIV and STDs. Other strategies include access to clinical services, outreach to and targeted screenings of at-risk populations, behavioral interventions, and educational programs.
6. **Diverse Referral Approaches.** PCRS may be delivered through two basic approaches: provider referral, whereby the PCRS provider locates and informs sex or needle-sharing partners of their exposure, and client referral, whereby the infected person takes responsibility for informing his or her partners. Sometimes a combination of these approaches is used.
7. **Support Services and Referral.** PCRS is delivered in a continuum of care that includes the capacity to refer S/NSPs to HIV counseling, testing, and treatment, as well as other services, e.g., STD treatment, family planning, violence prevention, drug treatment, social support, housing.
8. **Analysis and Use of PCRS Data.** PCRS specialists or program managers should collect data on services provided and use the data for evaluating and improving program efficiency, effectiveness, and quality.
9. **Counseling and Support for Those Who Choose To Notify Their Own Partners.** Counseling and support for those who choose to notify their own partners is an essential element of PCRS. Such efforts can assist in ultimately reaching more partners and minimizing unintended consequences of notification. Assistance to clients in deciding if, how, to whom, where, and when to disclose their infection can help them avoid stigmatization, discrimination, and other potential negative effects. Working with a client to think through what it means to

notify a partner and creating a specific plan to ensure he or she successfully accomplishes the notification is a vital role of the provider.

10. **Client-Centered Counseling.** Providing client-centered counseling for HIV-infected individuals and their partners can reduce behavioral risks for acquiring or transmitting HIV infection. In addition, client-centered counseling will help the provider understand the readiness of the client to notify partners. This will allow the provider to offer services to assist the client in successfully notifying partners without adverse consequence.
11. **Increased Importance as New Technologies Emerge.** As new technologies emerge, such as rapid diagnostic tests, vaccines, behavioral interventions, and even more effective therapies, PCRS will become an increasingly important prevention tool.
12. **Ongoing Access to PCRS for HIV-Infected Individuals and Partners.** PCRS should not be a one-time service. It should be offered as soon as a HIV-infected individual learns his or her serostatus and made available throughout that person's counseling and treatment. If new partners are exposed in the future, PCRS should be made available again. HIV-infected individuals should have the ability to access PCRS whenever needed.
13. **Assistance in Accessing Medical Evaluation and Treatment to Prolong Life.** S/NSPs might already be HIV-infected but be unaware of or deny their risks. They can be assisted through PCRS in learning their status, and in obtaining earlier medical evaluation and treatment for HIV disease and opportunistic infections. PCRS provides an opportunity for HIV primary prevention interventions for those partners not infected with HIV and an opportunity for secondary prevention for those partners living with HIV.

XIII.

RELEVANT CALIFORNIA HEALTH AND SAFETY CODES

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CALIFORNIA HEALTH AND SAFETY CODE

Partner Counseling and Referral Services

Section 121015

HIV Partner Counseling and Referral Services

121015. (a) Notwithstanding Section 120980 or any other provision of law, no physician and surgeon who has the results of a confirmed positive test to detect infection by the probable causative agent of acquired immune deficiency syndrome of a patient under his or her care shall be held criminally or civilly liable for disclosing to a person reasonably believed to be the spouse, or to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles, or to the county health officer, that the patient has tested positive on a test to detect infection by the probable causative agent of acquired immune deficiency syndrome, except that no physician and surgeon shall disclose any identifying information about the individual believed to be infected.

(b) No physician and surgeon shall disclose the information described in subdivision (a) unless he or she has first discussed the test results with the patient and has offered the patient appropriate educational and psychological counseling, that shall include information on the risks of transmitting the human immunodeficiency virus to other people and methods of avoiding those risks, and has attempted to obtain the patient's voluntary consent for notification of his or her contacts. The physician and surgeon shall notify the patient of his or her intent to notify the patient's contacts prior to any notification. When the information is disclosed to a person reasonably believed to be a spouse, or to a person reasonably believed to be a sexual partner, or a person with whom the patient has shared the use of hypodermic needles, the physician and surgeon shall refer that person for appropriate care, counseling and follow-up. This section shall not apply to disclosures made other than for the purpose of diagnosis, care, and treatment of persons notified pursuant to this section, or for the purpose of interrupting the chain of transmission.

(c) This section is permissive on the part of the attending physician, and all requirements and other authorization for the disclosure of test results to detect infection by the probable causative agent of acquired immune deficiency syndrome are limited to the provisions contained in this chapter, Chapter 10 (commencing with Section 121075) and Sections 1603.1 and 1603.3. No physician has a duty to notify any person of the fact that a patient is reasonably believed to be infected by the probable causative agent of acquired immune deficiency syndrome.

(d) The county health officer may alert any persons reasonably believed to be a spouse, sexual partner, or partner of shared needles of an individual who has tested positive on a test to detect infection by the probable causative agent of acquired immune deficiency syndrome about their exposure, without disclosing any identifying information about the individual believed to be infected or the physician making the report, and shall refer any person to whom a disclosure is made pursuant to this subdivision for appropriate care and follow-up. Upon completion of the county health officer's efforts to contact any person pursuant to this subdivision, all records regarding that person maintained by the county health officer pursuant to this subdivision, including but not limited to any individual identifying information, shall be expunged by the county health officer.

(e) The county health officer shall keep confidential the identity and the seropositivity status of the individual, and the identities of the persons contacted, as long as records of contacts are maintained.

(f) Except as provided in Section 1603.1 or 1603.3, no person shall be compelled in any state, county, city, or local civil, criminal, administrative, legislative, or other proceedings to identify or provide identifying characteristics that would identify any individual reported or person contacted.

CALIFORNIA HEALTH AND SAFETY CODES

Health Officer Authority and STD Related Codes

Section 120175

Duty of Health Officers to Prevent Spread of Disease.

Each health officer knowing or having reason to believe that any case of the disease made reportable by regulation of the department, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

4. Discretion

... Except for duty to report occurrence of certain diseases to state department of public health, local public health officer is vested with considerable discretion as to what actions he should take to control spread of infectious disease.

Section 120290

Willful Exposure to Communicable Diseases Other Than HIV - Misdemeanor Violation.

Except in the case of the removal of an afflicted person in a manner the least dangerous to the public health, any person afflicted with any contagious, infectious, or communicable disease who willfully exposes himself, and any person who willfully exposes another person afflicted with the disease, is guilty of a misdemeanor.

Section 120575

Local Health Officers: Investigation and Preventative Measures

It is the duty of the local health officers to use every available means to ascertain the existence of cases of infectious venereal diseases within their respective jurisdictions, to investigate all cases that are not, or probably are not, subject to proper control measures approved by the board, to ascertain so far as possible all sources of infection, and to take all measures reasonably necessary to prevent the transmission of infection.

Section 120580

Authorization of STD (VD) Investigators to Perform Venipuncture

Notwithstanding any other provision of law, a person employed by a public health department as a venereal disease case investigator may perform venipuncture or skin puncture for the purpose of withdrawing blood for test purposes, upon specific authorization from a licensed physician and surgeon, even though he or she is not otherwise licensed to withdraw blood; provided that the person meets all of the following requirements.

(a) He or she works under the direction of a licensed physician and surgeon.

(b) He or she has been trained by a licensed physician and surgeon in the proper procedures to be employed when withdrawing blood, in accordance with training requirements established by the board, and has a statement signed by the instructing physician and surgeon that the training has been successfully completed.

FEDERAL FUNDING LAW - SPOUSAL NOTIFICATION

Ryan White Care Act, Part B, Title II, 5/20/96

The Secretary of Health and Human Services shall not make a grant under part B of title XXVI of the Public Health service Act (42 U.S.C. 300ff – 21 et seq) to any State unless such State takes administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to the human immunodeficiency virus and should seek testing.

CALIFORNIA HEALTH AND SAFETY CODES

HIV Confidentiality, Charting, Disclosure and Consent

Section 120975

Confidentiality Protections Regarding Subjects of HIV Tests

To protect the privacy of individuals who are the subject of blood testing for antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS) the following shall apply: Except as provided in Section 1603.1 or 1603.3, as amended by Chapter 23 of the Statutes of 1985, no person shall be compelled in any state, county, city, or other local civil, criminal, administrative, legislative, or other proceedings to identify or provide identifying characteristics that would identify any individual who is the subject of a blood test to detect antibodies to the probable causative agent of AIDS.

Section 120980

Disclosure Laws, Including Parameters and Penalties

(a) Any person who negligently discloses results of a HIV test, as defined in Section 120775, to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, shall be assessed a civil penalty in an amount not to exceed one thousand dollars (\$1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(b) Any person who willfully discloses the results of a HIV test, as defined in Section 120775, to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, shall be assessed a civil penalty in an amount not less than one thousand dollars (\$1,000) and not more than five thousand dollars (\$5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully or negligently discloses the results of a HIV test, as defined in Section 120775, to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars (\$10,000) or both.

(d) Any person who commits any act described in subdivision (a) or (b) shall be liable to the subject for all actual damages, including damages for economic, bodily, or psychological harm that is a proximate result of the act.

(e) Each disclosure made in violation of this chapter is a separate and actionable offense.

(f) Except as provided in Article 6.9 (commencing with Section 799) of Chapter 1 of Part 2 of Division 1 of the Insurance Code, the results of a HIV test, as defined in Section 120775, that identifies or provides identifying characteristics of the person to whom the test results apply, shall not be used in any instance for the determination of insurability or suitability for employment.

(g) "Written authorization," as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

(h) Nothing in this section limits or expands the right of an injured subject to recover damages under any other applicable law. Nothing in this section shall impose civil liability or criminal sanction for disclosure of the results of tests performed on cadavers to public health authorities or tissue banks.

(i) Nothing in this section imposes liability or criminal sanction for disclosure of a HIV test, as defined in Section 120775, in accordance with any reporting requirement for a diagnosed case of AIDS by the department or the Centers for Disease Control under the United States Public Health Service.

(j) The department may require blood banks and plasma centers to submit monthly reports summarizing statistical data concerning the results of tests to detect the presence of viral hepatitis and HIV. This statistical summary shall not include the identity of individual donors or identifying characteristics that would identify individual donors.

(k) "Disclosed," as used in this section, means to disclose, release, transfer, disseminate, or otherwise communicate all or any part of any record orally, in writing, or by electronic means to any person or entity.

(l) When the results of a HIV test, as defined in Section 120775, are included in the medical record of the patient who is the subject of the test, the inclusion is not a disclosure for purposes of this section.

Section 120985

Charting and Disclosure from Provider to Provider

(a) Notwithstanding Section 120980, the results of a HIV test that identifies or provides identifying characteristics of the person to whom the test results apply may be recorded by the physician who ordered the test in the test subject's medical record or otherwise disclosed without written authorization of the subject of the test, or the subject's representative as set forth in Section 121020, to the test subject's providers of health care, as defined in subdivision (d) of Section 56.05 of the Civil Code, for purposes of diagnosis, care, or treatment of the patient, except that for purposes of this section "providers of health care" does not include a health care service plan regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2.

(b) Recording or disclosure of HIV test results pursuant to subdivision (a) does not authorize further disclosure unless otherwise permitted by law.

Section 120990

Written Consent for HIV Testing

(a) Except in the case of a person treating a patient, no person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test or the written consent of the subject, as provided in Section 121020, and the person giving the test shall have a written statement signed by the subject or conservator or other person, as provided in Section 121020 confirming that he or she obtained the consent from the subject. In the case of a physician and surgeon treating a patient, the consent required under this subdivision shall be informed consent, by the patient, conservator, or other person provided for in Section 121020. This requirement does not apply to a test performed at an alternative site, as established pursuant to Sections 120885 to 120895, inclusive. This requirement also does not apply to any blood and blood products specified in paragraph (2) of subdivision (a) of Section 1603.1. This requirement does not apply when testing is performed as part of the medical examination performed pursuant to Section 7152.5.

(b) Nothing in this section shall preclude a medical examiner or other physician from ordering or performing a blood test to detect antibodies to the probable causative agent of AIDS on a cadaver when an autopsy is performed or body parts are donated pursuant to the Uniform Anatomical Gift Act, provided for pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7.

(c) The requirements of subdivision (a) do not apply when blood is tested as part of a scientific investigation conducted either by medical researchers operating under institutional review board approval or by the department in accordance with a protocol for unlinked testing. For purposes of this section, unlinked testing means that blood samples are obtained anonymously or that the individual's name and other identifying information is removed in a manner that precludes the test results from ever being linked to a particular individual in the study.

Section 121010

Other Allowable Disclosures

Notwithstanding Section 120975 or 120980, the results of a blood test to detect antibodies to the probable causative agent of AIDS may be disclosed to any of the following persons without written authorization of the subject of the test:

(a) To the subject of the test or the subject's legal representative, conservator, or to any person authorized to consent to the test pursuant to subdivision (b) of Section 120990.

(b) To a test subject's provider of health care, as defined in subdivision (d) of Section 56.05 of the Civil Code, except that for purposes of this section, "provider of health care" does not include a health care service plan regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2.

(c) To an agent or employee of the test subject's provider of health care who provides direct patient care and treatment.

(d) To a provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7).

(e) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201). (2) For purposes of this subdivision, "designated officer" and "emergency response employee" has the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201). (3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

Section 121025.

General Protections and Fines for Negligent and/or Malicious Disclosures

(a) Public health records relating to acquired immune deficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by state or local public health agencies shall be confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

(b) State or local public health agencies may disclose personally identifying information in public health records, as described in subdivision (a), to other local, state, or federal public health agencies or to corroborating medical researchers, when the confidential information is necessary to carry out the duties of the agency or researcher in the investigation, control, or surveillance of disease, as determined by the state or local public health agency.

(c) Any disclosure authorized by subdivision (a) or (b) shall include only the information necessary for the purpose of that disclosure and shall be made only upon agreement that the information will be kept confidential and will not be further disclosed without written authorization, as described in subdivision (a).

(d) No confidential public health record, as described in subdivision (a), shall be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(e) Any person who willfully or maliciously discloses the content of any confidential public health record, as described in subdivision (a), to any third party, except pursuant to a written authorization, as described in subdivision (a), or as otherwise authorized by law, shall be subject to a civil penalty in an amount not less than one thousand dollars (\$1,000) and not more than five thousand dollars (\$5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the person whose record was disclosed.

(f) In the event that a public health record, as described in subdivision (a), is disclosed, the information shall not be used to determine employability, or insurability of any person.

Section 121030.

Exemptions.

(a) To the extent Chapter 7 (commencing with Section 120975) and Chapter 10 (commencing with Section 121075) apply to records or information that would be covered by this chapter, Chapters 7 and 10 shall supersede this chapter.

(b) This chapter supersedes Section 100330 to the extent it applies to records or information covered by Section 100325 or 100330.

CALIFORNIA HEALTH AND SAFETY CODES

WILLFUL EXPOSURE

120290. Except as provided in Section 120291 or in the case of the removal of an afflicted person in a manner the least dangerous to the public health, any person afflicted with any contagious, infectious, or communicable disease who willfully exposes himself or herself to another person, and any person who willfully exposes another person afflicted with the disease to someone else, is guilty of a misdemeanor.

120291. (a) Any person who exposes another to the human immunodeficiency virus (HIV) by engaging in unprotected sexual activity when the infected person knows at the time of the unprotected sex that he or she is infected with HIV, has not disclosed his or her HIV positive status, and acts with the specific intent to infect the other person with HIV, is guilty of a felony punishable by imprisonment in the state prison for three, five, or eight years. Evidence that the person had knowledge of his or her HIV positive status, without additional evidence, shall not be sufficient to prove specific intent.

(b) As used in this section, the following definitions shall apply: (1) "Sexual activity" means insertive vaginal or anal intercourse on the part of an infected male, receptive consensual vaginal intercourse on the part of an infected woman with a male partner, or receptive consensual anal intercourse on the part of an infected man or woman with a male partner. (2) "Unprotected sexual activity" means sexual activity without the use of a condom.

(c) (1) When alleging a violation of subdivision (a), the prosecuting attorney or grand jury shall substitute a pseudonym for the true name of the victim involved. The actual name and other identifying characteristics of the victim shall be revealed to the court only in camera, and the court shall seal that information from further revelation, except to defense counsel as part of discovery. (2) All court decisions, orders, petitions, and other documents, including motions and papers filed by the parties, shall be worded so as to protect the name or other identifying characteristics of the victim from public revelation. (3) Unless the victim requests otherwise, a court in which a violation of this section is filed shall, at the first opportunity, issue an order that the parties, their counsel and other agents, court staff, and all other persons subject to the jurisdiction of the court shall make no public revelation of the name or any other identifying characteristics of the victim. (4) As used in this subdivision, "identifying characteristics" includes, but is not limited to, name or any part thereof, address or any part thereof, city or unincorporated area of residence, age, marital status, relationship to defendant, and race or ethnic background.

120292. (a) Notwithstanding Chapter 7 (commencing with Section 120975) and Chapter 8 (commencing with Section 121025) of Part 4, identifying information and other records of the diagnosis, prognosis, testing, or treatment of any person relating to the human immunodeficiency virus (HIV) shall be disclosed in a criminal investigation for a violation of Section 120291 if authorized by an order of a court of competent jurisdiction granted after application showing good cause therefor. Any order of the court shall be issued in accordance with the following conditions: (1) An order shall not be based on the sexual orientation of the defendant. (2) In deciding whether to issue an order, the court shall weigh the public interest and the need for disclosure against any potential harm to the defendant, including, but not limited to, damage to the physician-patient relationship and to treatment services. Upon the issuance of an order of this nature, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose safeguards determined appropriate by the court against unauthorized disclosure. However, the court shall not order disclosure under this paragraph for any purpose other than a proceeding under this section. Any order for disclosure under this subdivision shall limit disclosure to those who need the information for the proceeding, and shall direct those to whom disclosure is made to make no further disclosure without permission of the court. The court shall grant permission for further disclosure when necessary for a proceeding under this section. Any disclosure in violation of an order issued under this section shall be remedied or punished as provided in Section 120980.

(b) Nothing in this section is intended to compel the testing to determine the HIV status of any victim of an alleged crime or crimes.

(c) Nothing in this section is intended to restrict or eliminate the anonymous AIDS testing programs provided for in Sections 120885 to 120895, inclusive. Identifying characteristics of persons who submit to that testing shall not be ordered disclosed pursuant to this section, nor shall an order be issued authorizing the search of the records of a testing program of that nature.

XIV.

FOOTNOTES

Footnotes

- ¹ Potterat et al, "Partner Notification' Early in the AIDS Era: Misconstruing Contact Tracers as Bedroom Police," *Research in Social Policy*, Volume 6, pp. 1-15, 1998.
- ² For HIV positive women who are pregnant or are considering pregnancy, appropriate treatment protocols using protease and reverse-transcriptase inhibitors are being referred to as "curative" measures if treatment is begun early enough.
- ³ West, G.R. and Stark, K.A., "Partner Notification for HIV Prevention: A Critical Reexamination," *AIDS Education and Prevention*, 9, Supplement B, 68-78, 1997.
- ⁴ National Alliance of State and Territorial AIDS Directors, HIV Prevention Fact Sheet, March, 2000.
- ⁵ California DHS/OA HIV Counseling and Testing Annual Report, 1997.
- ⁶ Report on highly active antiretroviral therapy (HAART) by Caro Research, Massachusetts, Reuters, 9/27/99.
- ⁷ Biological motivators can include health messages about the effects of co-infection with HIV and STDs, STD symptoms that can facilitate HIV transmission, possible infertility from untreated STDs, and the reduction in efficacy of treatment of HIV/STD when co-infection exists.
- ⁸ Referral agreements between public health and community based programs or private practitioners should be written "mini-contracts" that specify the type of services available a little or no cost to the client and include a time frame within which the agreement will be honored.
- ⁹ Ryan White Care Act Amendments of 1996 (Public Law 104-146, Section 8[a])
- ¹⁰ In November 1999, the Local Assistance Branch Field Services Section became the "Program Operations Unit" within the STD Control Branch.
- ¹¹ All data reported by the local PCRS program to the DHS/OA is stripped of client identifiers.
- ¹² The ten-year rule applies only to legally recognized marriages as defined by law.
- ¹³ "Pertinent partner information" applies to information disclosed by clients during the risk assessment session that would be important for a PCRS *elictor* to know, such as: present or past marital status, willingness to explore PCRS if infected, steady partner, domestic or other partner violence concerns, multiple risk histories in the distant past, denial, etc.
- ¹⁴ Referred to as the Counseling and Testing Report (CTR) form in the 1997 DHS/OA HIV C&T Guidelines, the HIV Counseling Information Form (CIF) is the billing invoice implemented in DHS/OA-funded HIV C&T sites.
- ¹⁵ The DHS STD Control Branch may also provide PCRS assistance to local C&T programs. Regional STD field offices are listed in the Appendix, page A-18.
- ¹⁶ Outreach staff should only facilitate, or introduce, the field person to the named partner and then remove themselves from the room or encounter while the field staff informs the partner. Without partner consent, no third parties may be present during the notification process. If the partner requests that the outreach worker be involved in the session, it is strongly recommended that written consent be obtained specifying the partner's wishes.
- ¹⁷ Since some of the clients targeted for these services are injection drug users (IDU), the reader may wish to refer to Section VII, page 48, of this document for information regarding offering PCRS to IDUs.
- ¹⁸ The DHS STD Control Branch may also provide PCRS assistance to local C&T programs. Regional STD field offices are listed in the Appendix, page A-18.
- ¹⁹ Ibid.

- ²⁰ Ibid.
- ²¹ Ibid.
- ²² Ibid.
- ²³ For more information about HIV/AIDS Surveillance, including special investigations, please refer to the California DHS, AIDS Surveillance Guidelines, 1995.
- ²⁴ Please refer to Section VI, "Working with Partners," page 39, for information regarding acceptance of PCRS requests from private physicians and other "outside" providers.
- ²⁵ The DHS STD Control Branch may also provide PCRS assistance to local C&T programs. Regional STD field offices are listed in the Appendix on page A-18.
- ²⁶ A sample "Authorization to Notify Exposed Sex and Needle-Sharing Partners" is provided in English and Spanish in the Appendix, pages A-7 and A-8.
- ²⁷ "Partner/Spousal Notification" will be updated to "PCRS" in future printings of the CIF.
- ²⁸ If the client is reached by telephone, the test result is never disclosed. The client must be scheduled for a face-to-face disclosure session, either in the C&T clinic or other acceptable, confidential location.
- ²⁹ Field procedures are discussed more thoroughly in Section VI, "Working with Partners."
- ³⁰ Regional and Area Field Offices administered by the State Health Department, STD Control Branch are provided in the Appendix, page A-18.
- ³¹ The DHS/OS Basic I and II courses are required of all HIV test counselors. Nurse case managers, social workers, other case managers and risk reduction specialists have professional skills and licensure in counseling and, therefore, would only be required to attend the PCRS Elicitation Training to learn how to elicit adequate partner identifying and locating information.
- ³² Contact the local HIV C&T Coordinator for information regarding the HIV Counselor Training Program courses. The PCRS and ISTD Courses are available to designated staff through the STD/HIV PTC.
- ³³ A brief description of the Five Steps for Working with Original Clients is provided in the Appendix, pages A-20 through A-23.
- ³⁴ DHS/OA is developing an educational brochure specifically designed for partners of HIV positive persons. Field workers who will be informing partners will primarily use this brochure.
- ³⁵ Landis *et al.* Results of a randomized trial of partner notification in cases of HIV infection in North Carolina. NEJM 1992; 326:101-6.
- ³⁶ Please refer to Section VIII, "Data Collection and Reporting," page 54 for information about the minimal required information needed to initiate a provider follow-up of a named partner.
- ³⁷ Verifying that partners are informed by the OC is critically important. Ways to verify a referral could include a phone call from the OC to the elicitor, verification of a medical visit, or a phone call from the partner.
- ³⁸ Please refer to Section IX for more information regarding domestic and other partner violence issues.
- ³⁹ The Detuned EIA is a new laboratory test that can predict whether an individual has become infected within the past 4 to 6 months. Not yet FDA-approved for routine analysis of confirmed positive specimens, this test is not widely available.
- ⁴⁰ Although any form of blood to blood or bodily fluid exchange can be risky for HIV transmission, injection drug use, anal sex, and vaginal sex are the three behaviors most likely to cause HIV transmission/contraction.

- ⁴¹ This and other California Health and Safety Codes are provided in Section XIII, "Relevant California Health and Safety Codes."
- ⁴² Please refer to Section VI, page 39, for a description of policy and recommendations on accepting PCRS requests from private and CBO physicians.
- ⁴³ Area and Regional STD Field Offices and contacts are listed in the Appendix, page A-18.
- ⁴⁴ See Health and Safety Code Section 121015.
- ⁴⁵ A sample letter format (in English and Spanish) for notifying exposed persons of the urgent need to contact a specific health department representative can be found in the Appendix, pages A-9 and A-10.
- ⁴⁶ English and Spanish "Authorization to Release HIV Specific Information" forms are provided in the Appendix.
- ⁴⁷ Health and Safety Code Sections 120291 *et seq* address willful exposure penalties.
- ⁴⁸ HIV PCRS Disposition Codes are defined on page 57.
- ⁴⁹ The FR is a CDC designed tool that is utilized by the field worker during the partner follow-up process. Information on the FR is transcribed from notes taken by the elicitor during the initial session with the OC.
- ⁵⁰ A complete listing of California ICCR desks is provided in the Appendix.
- ⁵¹ A brief, single-paged disposition chart is provided in the Appendix.
- ⁵² "Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers," produced by the Family Violence Prevention Fund, San Francisco, CA.
- ⁵³ "Reasonable security" should include an executed safety plan developed as a result of intensive counseling with a professional therapist that protects the potential victim(s) from any foreseeable harm.
- ⁵⁴ The DHS/OA HIV Counselor Training Program is currently offering a one-day continuing education training (CET) addressing D/PV assessment and referral for HIV test counselors.

XV.

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Working with Original Clients – the Five PCRS Steps

I. Transition

“You mentioned your partner earlier; I wonder if you want to talk about his or her needs now.”

Depending on the venue in which the elicitation takes place, the provider will need to make a transition to the topic of partners. In most cases this can be easily accomplished with a single phrase. The transition is simply a “line” which enables the discussion to switch to the topic of partners.

II. Describing Partner Referral Options

“We can discuss ways in which you can have your partners notified. You may want to begin thinking about which ones you would like to tell yourself and which ones you would like us to tell for you, keeping your name out of it. There are a number of options we can talk about.”

Before a client can decide whether or to what extent s/he will voluntarily participate in PCRS, the client must understand that there are a variety of available options regarding **who** will contact partners. There are basically two *types* of partner referrals: client only referrals and provider-assisted referrals. “Client only” referrals require the original client to self-disclose his/her sero-status to a partner. “Provider-assisted” referrals generally describe any referral that could directly involve the PCRS provider, namely: contract, provider-only, or dual referral types.

1. **Client-Referral** – The original client notifies and refers partner(s). Sometimes referred to as “self-referral.”

Risks: Loss of confidentiality; potential loss of relationship; inaccurate information about risk, testing options, treatment, etc. may be conveyed; inability to control partner’s extreme reaction(s); possibility that referral will not take place or will not occur in a timely manner.

Benefits: Establishing trust; potential immediate referral; possibility of maintaining personal relationship(s); minimal cost to public health.

2. **Contract-Referral** – Original client agrees to refer partner(s) by a specified date and to a method of verifying that partner(s) have been referred. If not verifiable, the PCRS program has the information to conduct a provider-only referral.

Risks: Similar to client-referral if original client notifies partner.

Benefits: Original client can attempt to notify and know there will be a back up plan if he/she changes mind; PCRS program maintains some level of contact with original client; public health can verify partner(s) were notified.

3. Provider-Referral – PCRS program staff notifies, counsels and refers partner(s).

Risks: Notifier may not be able to locate the partner; partner may assume correctly that the original patient disclosed his/her name and retaliate; can be a costly public health process.

Benefits: Partner will be notified, counseled and referred by a trained specialist; partner will receive accurate information about his/her risk, next options, etc.; public health will have knowledge that PCRS was conducted.

4. Dual-Referral – Counseling staff and HIV positive client notify partner(s) together.

Risks: Loss of confidentiality; partner's possible extreme reaction directed towards the original client or the counselor; counselor's inability to respond simultaneously to the needs of both the original client and the partner.

Benefits: Original client can rely on the notifier for information and support; partner can also ask questions of a trained professional; PCRS program knows partner was informed; testing may be immediately available if partner wants to know his/her serostatus.

III. Elicitation of Partner Names

"In order for us to be able to contact your partner(s), I need to obtain some specific information from you about where I can find them. All information is confidential; and, again, we will never disclose your name."

Elicitation means gathering a partner's name, specific exposure periods and types of exposure, information about where the partner lives, hangs out, works, and identifying characteristics. The partner elicitation process must never be rushed or hurried. Partner information must be carefully, consistently, and exhaustively pursued. Every effort must be made to obtain at least four pieces of locating information with address and telephone number counting as one and age, race and physical description counting as one. Before a partner is initiated for field follow-up, the PCRS elicitor must be reasonably certain that this individual has potential for exposure and can be located.

A Counselor's Approach to Elicitation

As the counselor begins to explore the original client's partner history, he or she must be able to move the session along smoothly, maintaining an appropriate level of eye contact while taking brief notes on a blank sheet of paper. Official forms must be kept out of the client's view. Clients may have overbearing feelings of guilt about potentially putting other people at risk, and counselors must be sensitive to and aware of the client's reactions as partners are discussed. Guilt emotions, like many feelings, may be displayed differently by different people. Extreme reactions

of anger, laughter, silence and even excessive talking could be typical client responses. Counselors must pick up on client cues and acknowledge the difficulty of going through this process, while again stressing the confidential nature of PCRS, in order to keep clients focused on the purpose and the need to have partners informed.

IV. Developing a Partner Referral Plan and Coaching the Original Client

“How do you want this to happen? Is there any special order that you would want us to follow as we notify your partner(s)?”

Once the provider and client have established which partners are to be notified, they can begin developing an appropriate referral plan. This process involves specific planning around how and in what order each partner is to be notified. It should be discussed with original clients regardless of whether client- or provider-referral options are going to be implemented. Planning includes any of the following:

1. Prioritization of which partner will be informed first, second, etc;
2. Setting appropriate times (of the day or night) for notifications and referrals to be made;
3. Determining how each partner will be notified (client-, dual-, contract-, or provider-only);
4. Coaching on how partners will be notified for client-referrals; and,
5. Planning for how the original client may react if a partner approaches him/her after a provider-only referral has taken place.

After partners have been informed of their risk, the PCRS elicitor should arrange to follow-up with the original client to attend to concerns, repercussions or feelings that may have arisen. Additionally, PCRS elicitors should always give clients a telephone number by which to contact them in case clients have second thoughts, want to change their notification plan, or simply need support. PCRS is an ongoing process, therefore a strong counselor-client relationship may result in more successful interventions initially as well as in the future.

5. Summary

“We’ve talked about a lot today and I appreciate your patience with me and the discussions we’ve had. Just to be sure, let’s talk right now about what you plan to do next. Then we can revisit the referral plan we discussed. I’d also like to schedule another appointment with you if possible, so that I can answer any other questions or concerns you may have at that time.”

The first phase of the summary is to help clarify the meaning of the PCRS elicitation session. It offers an opportunity to review any agreements the provider and client have made about partner referrals. For clients who are most concerned about

confidentiality, the provider can take the time to remind them of how confidentiality is maintained. The provider should also schedule a follow-up visit or telephone consultation to check in with the original client. Since elicitation may be part of a positive test disclosure or other type of counseling session, the provider must make the transition back to the presenting concern, discuss local referrals available to the client, and close that session appropriately.

The closure process can make a big difference in how – or if – partners are notified. The provider will have presented a large amount of information during the session and will want to have some reasonable assurance that the original client's needs have been met and that any additional needs that may come up can be dealt with at another time.

Domestic and Other Partner Violence (D/PV) Assessment Guidelines for HIV C&T Venues

Where do D/PV questions fit within the HIV risk assessment session?

- during the sexual history
- during the discussion of how one might react to testing positive
- whenever partners are discussed

How does a counselor bring up the topic?

Try framing the discussion with a general statement like:

"I review this area with all my clients ..."

If the counselor feels s/he is working with an abuser/batterer, scan the topic:

"How do you deal with arguments within your family?"

For a more direct approach with potential or suspected abusers/batterers:

"Do you ever have trouble with anger?"

"Do you ever do anything when you're angry that you wish you had not have done?"

"Has your anger ever gotten you into trouble?"

"When you become really angry with your partner, how do you deal with the anger?"

"It's not okay to hit your partner. There are resources available that may help you control your anger."

If the client is suspected to be a victim, ask direct questions like:

"Sometimes people react in a violent way when they are afraid of what their HIV test result might be."

"How might your partner react?"

"Does your partner hit, punch, slap or kick you or hurt you in any way?"

"Does s/he do any of these things to your children?"

"Are you in a relationship with a person who threatens or physically harms you?"

"Is your partner hurting or abusing you?"

"Is it safe to go home?"

"Are your children or other dependents safe?"

For MSM/WSW clients, it may not be necessary to ask questions differently, however, "third personing" a question like the following may help to open the discussion:

"Some of the men/women I work with are hurt by their male/female partners. Are you in a relationship with a man/woman who hurts you? Are you afraid of him/her?"

Recognizing the Pattern of Abuse

Once a counselor begins to ask open-ended questions about D/PV, it is important to know what the indicators of violence and danger may look like. Many signs of physical and emotional abuse exist, however, not all persons perceive them the same way. There are varying degrees of abuse as well, so the following examples of DV cannot be conclusive:

- an increase in the frequency and severity of assaults
- increasing or new threats of homicide or suicide by the batterer
- batterer is severely depressed
- threats made to the client, children, pets, or extended family members
- violence by the batterer outside the home
- presence of, or availability of, a weapon, especially a firearm
- drug and/or alcohol abuse by the batterer
- obsession about the victim, including stalking, extreme jealousy, accusations of infidelity
- hostage-taking behavior
- forced sexual encounters (rape)
- rage by the batterer at possibly being left by the client
- decreased remorse expressed by the batterer

California ICCR Desks

In California, there are eleven area Interstate Communication Control Registry (ICCR) desks that can accept and delegate follow-up requests between counties/jurisdictions within California. A local PCRS program representative needs to contact their closest ICCR desk to request out-of-jurisdictional follow-up, should the partner be currently residing within California. The headquarters ICCR desk in Sacramento will accept and delegate follow-up requests between California and other states, territories and countries.

	<u>Telephone #</u>	<u>Fax #</u>
<u>Headquarters</u> – Sacramento (out-of-state contacts)	(916) 322-9752	(916) 322-5447
ΦΦΦΦ	ΦΦΦΦ	ΦΦΦΦ

Area ICCR Desks

Area 1	Sacramento	(916) 227-0445	(916) 227-0451
Area 2	Stockton	(209) 468-3845	(209) 948-7473
Area 3	Oakland	(510) 628-7720	(510) 628-7897
Area 5	Fresno (HIV) Fresno (STD)	(559) 445-3325 (559) 445-3592	(559) 445-3331
Area 6	Bakersfield	(661) 868-0347	(661) 868-0215
Area 7	Long Beach	(562) 570-4369	(562) 570-4190
Area 8	San Diego	(619) 692-8501	(619) 692-8541
Area 9	Riverside	(909) 358-6009 (909) 358-6011	(909) 358-6007
San Bernardino		(909) 383-3060	(909) 383-3212
Los Angeles		(213) 744-5970	(213) 749-9640
San Francisco		(415) 487-5531	(415) 431-4628

HIV PCRS DISPOSITION CODES

01 Previous Positive

02 Previous Negative, New Positive

03 Previous Negative, Still Negative

04 Previous Negative, Not Re-Tested

05 Not Previously Tested, New Positive

06 Not Previously Tested, New Negative

07 Not Previously Tested, Not Tested Now

08 Partner/Positive Test Patient Notified

09 Partner Notified, States Previously Counseled and Tested

G Insufficient Information to Begin Investigation

H Unable to Locate

J Located, Refused Examination

K Out of Jurisdiction

L Other

The Spousal Notification Requirement

Local Health Jurisdictions must consider Public Law 104-146, Section 8[a] of the Ryan White CARE Act Amendments of 1996. This mandate requires that, in order to be eligible for federal Ryan White funding, a state or entity must make a good faith effort to notify spouses of their possible exposure to HIV.

Spouses are defined as "... any individual which is the marriage partner of a HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10 year period prior to the diagnosis of HIV infection."

Examples of a Good Faith Effort: (provided by CDC)

- ◆ Asking all HIV positive clients if they have a current or past marriage partner within the past 10 years;
- ◆ Notifying these partners of their possible exposure to HIV;
- ◆ Referring them to appropriate prevention services; and,
- ◆ Documenting these efforts.

DHS/OA Documentation of Good Faith Effort To Notify Spouses:

- ◆ The HIV C&T Counseling Information Form contains four fields that can be used to document HIV PCRS referrals:
 1. "Client Was Referred By" – check "2"
 2. "Client's Reason for Testing" – check "3" or "4"
 3. "Referrals" – enter a 1, 2, or 3 as appropriate in the disclosure column for option number "15."
 4. "Client Sexual Risk History" – enter the appropriate number to indicate how many years ago in the HIV infected partner option. Also include information on barrier use with this partner and whether the client knew of partner's HIV positive status prior to intercourse as appropriate.
- ◆ PCRS data collection and reporting forms document PCRS elicitation sessions and notification, counseling and referral of partners;
- ◆ PCRS data collection forms include a field to document spousal exposures;
- ◆ Counseling and referral of potentially exposed spouses is conducted in agreement with DHS/OA guidance as set forth in the *California HIV PCRS Standards and Recommendations, 2000*.

Partner Referral Options – Benefits and Concerns

<u>Referral Option</u>	<u>Benefits</u>	<u>Concerns</u>
Client Referral	Potential for immediate notification. May deepen commitment between the OC and partner because of honesty and trust. Occurs at minimal cost to public health.	OC must self-disclose. Potential relationship loss. Potential violent outcome. Limited ability to verify referral
Contract-Referral	Empowers OC to notify yet provides for a Back up plan if needed. PCRS program maintains level of contact with the OC. Verification that the partner was notified.	Similar to client-referral risks if OC self-discloses.
Provider-Only	Partner will be notified, counseled and referred by a trained specialist. Partner will receive accurate information about personal risk, options for testing, course of HIV. Public health will have knowledge whether PCRS was conducted.	Partners may not be located. Partner may retaliate against OC. Can be costly to provide.
Dual-Referral	Counselor provides information and support. Testing may be immediately available PCRS program knows partner was informed. Partner can also ask questions of a trained counselor.	Loss of confidentiality. Difficult counseling process.

Basic Components of a PCRS Program or Local Referral System

DHS/OA is aware that many local health jurisdictions have already developed PCRS protocol and procedures. In some other jurisdictions, a system may be in place yet no written protocol exists that describes PCRS confidentiality procedures, staff responsibilities or program functions. Still other local health HIV programs have not identified a method by which HIV PCRS will be offered to clients and carried out when necessary and appropriate. Every jurisdiction is unique and PCRS systems should conform to local program structure and staff expertise. A basic PCRS system would include HIV and STD program staff, cross-training of staff, collaborative or coordinated supervision, and/or a mentoring protocol, to help ensure that clients and partners receive accurate information and appropriate care in the referral process.

DHS/OA suggests that local health jurisdictions consider the following administrative planning and development activities to build a comprehensive, skilled, client-focused PCRS program that will help ensure that all HIV positive clients are given easy access to a trained PCRS specialist. If, for any reason, PCRS cannot be provided directly by a local health department, then a speedy referral to a PCRS specialist must be implemented.

Identification of Appropriate Supervision and Staff

It is recommended that local health departments identify the most appropriate administrative placement of PCRS. Many jurisdictions have positioned PCRS within the context of HIV prevention services and assigned supervision to the HIV counseling and testing program coordinator, for instance. Others have chosen to provide PCRS through the local STD program. At minimum, local PCRS program planning must include HIV and STD provider input when determining how confidential and voluntary PCRS services can be offered and delivered on an ongoing basis. HIV counseling and testing, STD control, early intervention, surveillance, AIDS case management and Medi-Cal Waiver service administrators can be excellent resources when determining client access needs and staff expertise.

Establish Local Protocol and Procedures

Every PCRS program/specialist (or every system to refer clients needing PCRS assistance) should offer services that are consistent with DHS/OA PCRS standards and CDC PCRS principles, including but not limited to: policies of confidentiality, voluntary participation, staff training and records maintenance. These standards should be incorporated into site-specific procedures. Site procedures should be written and available for management and staff to review and give input. Local protocol should be developed to include quality assurance, staff review and program evaluation objectives and activities.

Involving the Community

Local health jurisdictions must include representatives from the HIV affected community in discussions of how best to serve them. Many people do not understand the voluntary and confidential nature of PCRS. Once they learn from the public health provider, they often see the extreme value of this service and will engage in a discussion of how to meet the needs of the various communities most affected by HIV.

Suggested Roles and Responsibilities

HIV PCRS can be viewed as a three-part process that involves: 1) introducing the concept to HIV positive clients; 2) assessing partner needs and determining methods to inform partners; and, if appropriate, 3) informing the potentially exposed sex or needle-sharing partner (S/NSP). PCRS activities can be offered and provided by different program staff or the same individual, depending upon program resources. For instance, a C&T counselor could work with the positive client to elicit partner names and a PCRS specialist or STD field worker could conduct the field notification, counseling and referral of partners.

PCRS Activities and Suggested Staff Responsibilities

ACTIVITY OR SERVICE

PROGRAM STAFF RESPONSIBLE

PCRS Is Introduced or Re-introduced To:

- ◆ To HIV risk assessment clients
- ◆ To HIV positive disclosure clients
- ◆ To HIV positive clients in STD, EIP, CMP or other counseling programs

Staff Who Introduce or Re-introduce PCRS:

- ◆ HIV test counselors
- ◆ HIV test counselors
- ◆ STD counselors who counsel HIV positive clients in the STD clinic; staff who work with HIV positive clients (case managers, social workers, HIV test counselors, surveillance staff)

Partner Elicitation

- ◆ For clients who elect to have partners notified by public health specialists
 - ◆ HIV positive C&T clients
 - ◆ Clients in T-Cell, EIP, CMP or other counseling program, STD clinics

Staff Who Elicit

- ◆ Must be PCRS trained staff such as STD counselors, case managers, social workers, HIV test counselors, nurse practitioners, physicians, public health nurses

Informing the Partner

- ◆ Client -referral
- ◆ Provider-referral (in the field)
- ◆ Dual-referral (in a clinic or other confidential setting)

Staff Who Facilitate/Conduct Partner Referrals

- ◆ Elicitor coaches client in ways to inform a partner. Must be a trained, experienced HIV or STD counselor. Must assess for potential of partner violence
- ◆ STD disease intervention specialists, public health nurses, HIV counselors or social workers who have field training and expertise and are capable of conducting HIV counseling (and testing if allowed) in the field
- ◆ Must be an experienced HIV counselor or licensed counselor capable of providing appropriate counseling to two persons simultaneously

EMPLOYEE STATEMENT
CHILD/DEPENDENT ADULT ABUSE REPORTING

CHILD ABUSE REPORTING

California Penal Code Section 11166.5 requires that the following statement be distributed to all “child care custodians,” “medical practitioners,” and “non-medical practitioners” who commence employment on or after January 1, 1986. California law requires that this statement be signed by the employee as a prerequisite to employment and retained by the employer.

- Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she suspects has been the victim of child abuse, to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

DEPENDENT ADULT ABUSE REPORTING

California Welfare and Institutions Code Section 15632 requires that the following statement be distributed to all “dependent adult care custodians,” “medical practitioners,” and “non-medical practitioners” who are employed after January 1, 1986. California law requires that this statement be signed by the employee as a prerequisite to employment and retained by the employer.

- Section 15630 of the Welfare and Institutions Code requires any care custodian, medical practitioner, non-medical practitioner, or employee of an adult protective services agency or a local law enforcement agency who has knowledge of, or observes a dependent adult in his or her employment, who he or she knows has been the victim of physical abuse, or who has injuries under circumstances which are consistent with abuse, where the dependent adult’s statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred, to report the known or suspected instance of physical abuse to an adult protective services agency immediately, or as soon as practically possible, by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

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